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Becoming aware of blind spots — Norm-critical perspectives on healthcare education

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Biology enables, culture forbids. (Harari, 2015, p. 147)

There must be more to the ego than psychological totalitarianism. (Billig, 1987, p. 157)

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Abstract

Background. This dissertation takes a critical look at norms and normality in healthcare education, focusing on the specific case of a nursing education programme at a Swedish university college. The concepts of norms and normality have a long history in healthcare professions, and have become important for many aspects of social life. A norm-critical perspective is central to the studies, as it exposes constructions of power and privilege related to norms and normality. It may also be useful in revealing underlying assumptions and matters which healthcare professionals take for granted, and which may result in failure to provide equitable care for all.

Aim. The overall aim of the dissertation is to describe and scrutinise norms and normality in a healthcare education context from a norm-critical perspective. A further aim is to explore how a norm-critical perspective on nursing education can contribute knowledge to existing fields of critical inquiry.

Designs. The four studies were designed using qualitative approaches to written and spoken text, as well as a number of different approaches to an instrument development process.

Methods. In study I, document analysis was underpinned by thematic analysis, while critical discourse analysis was used to analyse focus group discussions in study II. Study III analysed written responses to open survey questions using a discursive approach. Instrument development and factor analytic techniques were used in study IV.

Findings. Study I revealed the occasional use of politically correct rhetoric in curricular documents and literature, in parallel with a number of outdated views in terms of identity and normality. In study II, three discourses were identified in nursing teachers' talk, all with norm-critical potential, though criticism of norms was not strong enough to form a discourse of its own. Study III showed how nursing students used more or less politically correct or reflexive approaches to construct images of norms and normality. Study IV developed and validated the Norm-critical awareness scale.

Conclusions. This dissertation expands knowledge about norm-critical perspectives in healthcare contexts. It exposes constructions of normative, taken-for-granted aspects within healthcare education, and concludes that the apparently desirable concept of tolerance needs to be problematised more fully in relation to norms, privilege and power. Norm criticism as an educational and intellectual tool can increase awareness of the norm-related mechanisms underlying healthcare encounters, even if awareness is only a first and necessary phase of change, and is not in itself sufficient to bring about change.
Implications. In a practical sense, the findings can facilitate understanding, planning and implementation of further norm-critical initiatives in educational contexts. Where theory is concerned, the studies fill a knowledge gap by contributing to norm-critical approaches in settings where future healthcare professionals are being educated, which have barely been explored until now. The studies also add to existing research traditions involving critical, emancipatory and anti-oppressive perspectives in terms of healthcare professions.

Keywords. Discourse, Equality, Equity, Instrument development, Normality, Norm criticism, Norms, Nursing education

Original papers

This dissertation is based on the following papers, which are referred to in the text by their Roman numerals:

Paper I. Tengelin, E., Bülow, P., Berndtsson, I. & Dahlborg-Lyckhage, E. (2019). Norm-critical potential in undergraduate nursing education curricula: A document analysis. *Advances in Nursing Science*, 42(2), E24–E37. doi: 10.1097/ANS.0000000000000228.

Paper II. Tengelin, E. & Dahlborg-Lyckhage, E. (2017). Discourses with potential to disrupt traditional nursing education: Nursing teachers' talk about norm-critical competence. *Nursing Inquiry*, 24(1), e12166. doi: 10.1111/nin.12166.

Paper III. Tengelin, E., Dahlborg, E., Berndtsson, I. & Bülow, P. From political correctness to reflexivity: A norm-critical perspective on nursing education. *In manuscript*.

Paper IV. Tengelin, E., Cliffordson, C., Dahlborg-Lyckhage, E. & Berndtsson, I. (2019). Constructing the Norm-critical awareness scale: A scale for use in educational contexts promoting awareness of prejudice, discrimination, and marginalisation. *Equality, Diversity and Inclusion: An international Journal*. Advance online publication. doi: 10.1108/EDI-10-2017-0222.

I am the first author of all articles and have made significant contributions to research ideas, design, data collection, analysis and writing. The papers have been reprinted with the kind permission of the respective journal.

Contents

Introduction

The title of this dissertation is *Becoming aware of blind spots*. In formulating this title, I wished to highlight an objective of the norm-critical approach and allude to the conclusions drawn from the research. These involve raising awareness of assumptions about what and who is 'normal'. These assumptions, which are taken for granted, are carried within people and expressed as talk, thoughts and action. I have termed them 'blind spots'. 'Becoming aware' can refer to the participants in the studies, but also to the reader of this text, and of course to myself, the researcher.

Normality, or 'the normal', has developed into an indispensable concept for modern Western societies, but has not always been in this position (Hacking, 1990). Critique of normality is not new. There have been a number of explorations of how the normal is constructed in various contexts. An assumption of this type of research is that norms and normality are the ever-variable results of human beings' shared constructions, social relations and power struggles. This also forms one of the central assumptions of this dissertation.

Normality has been used in various ways through history to understand ill-health, disease and deviancy. Foucault (1963/2003) suggested that the development of the medical clinic in the 18th and 19th centuries made the human body the object of healthcare professionals' knowledge, expertise and power. In 19th century Western medicine, normality came to be the baseline from which physicians assessed pathological individuals (Canguilhem, 1966/1989). As medical science and practice developed, so did the assumption that 'the normal state' of individuals could be observed and quantified objectively. After the establishment of the biomedical model of health and disease, in which individuals were considered pathological if they deviated from a physiologically normal state, another kind of medicine began to develop, which reconstructed the

meaning of normality (Armstrong, 1995). Unlike clinical medicine, surveillance medicine blurred the distinction between normal and pathological individuals in its use of socio-medical surveys targeting whole populations. Individuals began to be classified as abnormal with reference to other individuals in the population, meaning that someone could feel healthy and free from disease, but still not be regarded as normal. The 'normal population' also became a frame of reference in healthy populations.

This dissertation takes a critical look at norms and normality in higher level healthcare education, with reference to a nursing education programme at a Swedish university college. The nursing context is important for these studies. With its roots in the mid-19th century, the nursing profession originally promoted a social view of human beings and their health, where living arrangements, family income and access to healthcare were seen as a strong influence on health (Falk-Rafael, 2005). Based on this social model of health, nurses cared for the whole individual (and whole community), as opposed to physicians who diagnosed people on the basis of physiological states which differed from the normal. With the rise of biomedical models explaining health and disease, such as germ theory, nursing had to adjust to the biomedical culture of healthcare. Nurses thus had to combine the social model of health with the biomedical (C. Brown & Seddon, 1996; Thurman & Pfitzinger-Lippe, 2017). This resulted in what is known as a 'holistic' approach to human beings, and is apparently unique to the practice of nursing. Despite attempts to position nursing knowledge as fundamentally different from the medical, it became influenced by medical models of health. 'The normal' also became relevant in nursing.

With the normal as a desirable state, not only in healthcare but in society as a whole, those who are considered to be in an undesirable state at certain times and in certain places, on the 'other' side of the boundaries of the normal, will experience discomfort. Being

categorised, defined and treated as ‘abnormal’, ‘different’ or ‘deviant’ is related to phenomena such as discrimination, stereotyping and exclusion (see, for example, Dervin, 2015; Elsrud, 2008; Fox, 2009; Johnson et al., 2004; Riach, 2007). Following this insight and the emancipatory initiatives which have emanated from it, *norm-critical pedagogy* was developed in the first decade of the 21th century in Sweden: an inclusive, anti-discriminatory approach intended to be used in educational settings. The basic tenets of norm criticism have since been applied to other areas, but not yet to healthcare education.

Using a norm-critical framework requires self-reflection from everyone involved. I believe this also includes me as a researcher, and I shall therefore briefly describe the position from which I have approached the work of this dissertation. I am not a healthcare professional myself, and when I began this work I had no deep theoretical knowledge on norms and normality. My motivation lay in a curiosity for norm-critical ideas and an interest in equitable health and care. Throughout my academic education I have been fascinated with how power can express itself in our everyday lives, and I have approached a variety of academic subjects from the fields of health, medicine and social studies where power to various extents has been discussed as a concept. This has given me a broad, multi-disciplinary knowledge base, but at the same time, a diverse theoretical approach to my dissertation work that has sometimes been difficult to manage.

This dissertation explores norms and normality in a nursing education programme, and involves texts, teachers, students and an instrument-development process. The nursing context therefore becomes as central to the studies as the educational context, as the profession and higher education are closely intertwined.

Outline of the dissertation

The dissertation begins with a chapter which sets out some conceptual starting points. These revolve around Western knowledge production in terms of the nature, meaning and construction of normality and differentness in healthcare contexts, as well as the tension between underlying epistemological assumptions. Chapter 2 continues the account of norms and normality, connecting it with a framework of inequity and internalised prejudice. The dissertation's central concept of norm criticism is presented in some detail, and the case explored in the four studies is introduced. Chapter 3 touches on the historical nursing context, along with the structure of nursing education in Sweden, and anti-oppressive, emancipatory approaches are presented which have developed within the field of nursing. A number of problematic aspects of nursing education are described, illustrating the need for a transformed approach. Chapter 4 presents the rationale and aims of the dissertation, highlighting its objectives and why this research is needed. Chapter 5 states the details of methods used in the studies, while Chapter 6 addresses research ethics. Summaries of the study findings are given in Chapter 7, and are discussed both separately and jointly in Chapter 8. Lastly, Chapter 9 sets out the conclusions and implications of the work. A Swedish summary is included before the references and the four attached studies.

Chapter 1. Some meanings of normality

> *The word normal is whispering in our ears that what is normal is also right. (Hacking, 1990, p. 160)*

There are distinctly different views on obtaining, approaching and legitimising knowledge about human beings and the differences between them. These conflicts will have implications for how the concept of 'normal' is demarcated, approached and criticised in any society. The aim of this chapter is to introduce epistemological foundations of 'differentness', the discussion about normality as normative or objective, the social meaning of norms and the phenomenon of normalisation, along with some examples of how professionals construct normality.

Epistemological foundations of 'differentness'

Questions of what is allowed to be normal in a society, according to whom and why, can be explored through the lens of diagnostics. Diagnoses represent ways of understanding 'differentness' as disease at a given time and within a given context of knowledge and which can be constructed from mental states as well as physical ones. They are 'commentaries on society' according to Johannisson (2006a), because 'each society has the morbidity it deserves' (p. 36). Diagnoses are changeable across time and place; what societies define as sickness and health can be viewed as expressions of its current culture and values. Throughout history, a variety of conditions have been medicalised for periods of time, and examples include nostalgia, homosexuality, fatigue, hysteria and masturbation (Conrad, 1992; Johannisson, 2006b). There are several possible motives for this type

of medicalisation, such as helping people, setting a political agenda or controlling people socially, but the effect has nevertheless been to exclude undesirable individuals from the social community. Demanding women have been diagnosed as 'hysterical', and disorderly children as 'hyperactive'. There is hardly an area in which hypothetical diagnoses have not been presented to support and confirm the values, attitudes and perceptions of risk which currently dominate society (Johannisson, 2006a). Today, diagnosis is very much used as a tool to individualise problems rather than attend to the norms and structures that affect people. This is particularly evident in the fact that 'differences' or 'deviances' can be de-medicalised. Sweden was the first country in the world to change the official view that homosexuality was a disease. It was de-medicalised by the Swedish Board of Health and Welfare in 1979, following pressure from peaceful activists. In a newspaper interview, one of the activists stated that it was homophobia, 'a pathological fear of homosexual people', that should be labelled a disease, rather than homosexuality itself (QX, 2015). The categorisation and medicalisation of disease is not a neutral result of apparently objective biological factors. Instead, it is crucial to pinpoint who is in a position of power to define it.

There are several aspects at play in the birth and success of a diagnosis and in shifting the boundaries around the normal. The biomedical model of knowledge, based on observations, measurements and rational thinking, plays an important role, though biomedicine alone can never anticipate or explain how a disease will be interpreted socially and societally. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is used as the basis for categorising psychiatric disease in a great deal of research and practice, and represents a dominant view of knowledge in healthcare. The assumptions underlying the DSM effectively exclude the social and cultural context of individuals' experience, instead assuming that diagnoses are strictly the consequences of patterns or syndromes that occur within them (Crowe, 2000). This, in turn, is underpinned by the

assumption that it is possible to distinguish between the world which is observed and the person who observes it (cf. Gergen, 2015); the observer and the context do not influence each other in any way. Thus, the knowledge resulting from a person's observation is naturally 'objective, value-free, inevitably progressive, and universal' (Cheek, 2000, p. 22). This observational approach to knowledge strengthened its position in the Western world during the Enlightenment, and assumed a continuous progression towards knowledge, freedom and truth. In this process, spiritual or moral ways of interpreting madness, for instance, were outmanoeuvred and replaced by a pathological perspective (see, for example, Johannisson, 1997). In the development of modernity, medicine delimited madness to pathological, biological deviance.

An alternative view on the knowledge which forms the basis of the normal/pathological distinction is that it is socially constructed, inseparably bound to power, and founded on sets of common assumptions which may be invisible to us and therefore easily taken for granted. The ability to distinguish between the observed and the observer is considered unlikely; all knowledge is constructed in relationships and is also open to change (Gergen, 2015). The assumptions that enable and constrain the production of knowledge are what Foucault termed 'discourses', a concept which exposes the fallacy that medical knowledge is apparently free from values. Discourses constitute objects in that they provide the basis for conscious knowledge (Foucault, 1972). Not all discourses are afforded equal presence and authority, however; some are marginalised, while others are given dominance. For example, in Lawler's view (2001), the dominant discourses of the modern period have submerged the subjective in the quest for the objective.

A discursive view on knowledge emphasises language use, and that the way we speak about things also constitutes the way we see them. The traditional view of language is as a reflection of the world, an

objective carrier of the truth, while a constructionist approach to knowing gives language a performative, or constitutive, role. Discourses play an integral part in constituting reality, and have the power to categorise behaviour as belonging within or outside the norms of some specific context (Crowe, 2000). This means that when a certain condition is given a name, it is at the same time created as a disease, because people will relate to it as such.

Different discourses are perpetuated by different professional groups in the healthcare system, but with unequal authority. Certain groups of health professions derive their expertise and authority from the scientific/medical discourse which, in turn, legitimates their authority (Cheek, 2000). Medical understanding of the body as a machine, for instance, has ruled out other ways of understanding the body, such as from a social perspective, which was the original model of interpretation in nursing (C. Brown & Seddon, 1996). Even though nursing as a profession attempts to advocate a 'holistic' view of the body, this view does not seriously challenge the biomedical one. Nursing is often positioned and portrayed in terms of its relation to medical discourse, rather than to any distinctive nursing discourse. This can be understood as a result of the power which positions nursing in one way rather than another (C. Brown & Seddon, 1996). The way nursing has adapted to medical discourse has been criticised for shifting the focus away from social justice, equality and other social aspects which used to be part of nurses' work (Thurman & Pfitzinger-Lippe, 2017).

Constructionist perspectives on knowing need to be approached carefully. They can be perceived as threatening, relativistic or oppressive. After all, they challenge four centuries of Western tradition. To some, they may even represent the erosion of beliefs central to our ways of life, and be considered to threaten traditions of democracy, religion, education and nationhood (Gergen, 2015). However, pointing out that there are constructed discourses about

normality does not mean that traditions as we know them should be silenced or overthrown. Instead, such a position shows that the traditional view of knowledge asserts a claim of universal truth over other views, not allowing parallel discourses to take place at the same time, and this prevents space being opened up for other ways of thinking (Cheek, 2000).

'The normal' as normative or objective

The discussion about the meaning of normality has been ongoing since the idea of 'the normal state' was introduced into Western medicine. From a biomedical perspective, the normal is descriptive, stable, observable and measurable, while the constructionist stance emphasises that normality is normative and involves what is desirable or undesirable in a certain social context, time and place. Remarkably, the normal seem to be both things at once – it blurs the line between fact and value.

When the term 'norm' first entered European languages in the 19th century, it was used as a geometrical term. The Latin word *norma* means 'straight', and refers to a line which is orthogonal to another line (Canguilhem, 1966/1989). First used by carpenters, then by physicians, 'the normal' has invaded every space of society today, including the social sphere. The term is now applied to phenomena as various as people, behaviour, states of affairs, diplomatic relations and molecules (Hacking, 1990).

Before the Enlightenment, the normal state and the pathological state were, from a medical perspective, seen as two qualitatively different states in a human being (Canguilhem, 1966/1989). This prevailed until the breakthrough of Broussais' principle in the late 18th century, which offered a new theory of disease, heavily promoted by Auguste Comte, the founder of positivism. The principle suggested that disease and

health were phenomena of essentially the same kind: human pathology is not qualitatively different from the normal (or natural) state. Their difference lay in their quantitative intensity on the same continuum. Only the level of excitation varied, so that there could be either deficiency or excess in a human body compared to the normal state, thus producing disease. Up until this point the normal had been of secondary medical interest, by definition the opposite of the pathological, but a consequence of the new principle was a change of position: the pathological was now defined as deviation from the normal. This required an objective definition of what a 'normal' human being was. However, in scrutinizing the works of Broussais, Canguilhem (1966/1989) concluded that 'the normal state' is described not as a disposition which can be revealed and explained as fact, 'but a manifestation of an attachment to some value' (p. 57). Using the terms 'more' or 'less' to define pathology presumes a norm to which changes are related, and this norm is not neutral but normative, connected to values of health and vitality.

In criticising the presumed objectivity of the normal state, Canguilhem also questioned the absence of an ontological conception of disease. The laws of vital phenomena cannot be the same for disease and for health, he claimed. Quantitative differences are only differences, and do not necessarily establish the acutely pathological. Simply being unusual in terms of quantitative measurement does not make something pathological or abnormal. Definitions of the pathological must, in fact, be grounded in subjective values such as the experiences and feelings of the patient. A physician treats patients, and 'is very often happy to agree with his patients in defining the normal and abnormal according to their individual norms' (p. 121). In other words, pathological as well as normal states must be normative, rather than objective. Measurements using the normal as a point of reference are not enough to define ill-health and disease in individuals.

Social norms and normalisation

Canguilhem (1966/1989) showed that the idea of the normal relates to a state of 'what ought to be' rather than a state of 'what is'. This confusion between what is and what ought to be has implications beyond medicine. In fact, it affects many aspects of social life. Social norms are generally viewed as necessary for human interaction, and are seen as rules of behaviour that individuals follow independently of legal obligation or formal penalty for noncompliance (Huntington, 2009). Canguilhem underlined that social norms are invented, not observed. Their power is founded on the fact that individuals are attentive to the views of others, generally seeking their approval and avoiding disapproval. The concept of social norms may seem like a neutral term, but is really anything but neutral, and affects many decisions considered private matters, such as family relationships (see, e.g., Huntington, 2009). Butler (1993) claims that norms are essential in making gender, sex and desire intelligible, and Philips (2014) describes norms as social discourses which can become so internalised that individual behaviours and beliefs about oneself, others and the world appear innate, from a fixed biological core. In this sense, norms not only describe an ideal (like the carpenter's square), they also prescribe demands to be obeyed, and direct the purified state to which we should all strive.

In Foucault's view, norms are the tools through which power operates. Social relations between the normal and the deviant originate in historical processes of power/knowledge, and this term addresses the cultural disciplining that takes place in our societies (Foucault, 1982). Wherever there is power there is knowledge, because knowledge (or truth) is defined by those with power. Defining knowledge means having power at the same time, because there are no 'pure' forms of knowledge. All knowledge is constructed from a social position.

Historically and culturally, certain social identities have been constructed as different, deviant or pathological in relation to the normal, sometimes under labels of diagnoses. In these processes of differentiation, power and knowledge is central. Becker (1963/1997) states that discourses about normality and deviance can only be dictated by those who are powerful enough to do so. It is impossible to find a norm that includes everybody's view of what the right, healthy and good is. To identify a characteristic as normal, it has to be reflected in something which is considered deviant and abnormal. Major institutions in our society lay claim to the knowledge which underpins these kinds of consideration, resulting in the classification of people as intelligent or unintelligent, healthy or unhealthy, guilty or innocent. The remarkable thing is that, most of the time, we accept this disciplining, we 'participate in our own enslavement' (Gergen, 2015). We use the terminology of these institutions in our daily conversations, accept their ways of classifying us and struggle to attain the norms they have established. We identify ourselves in relation to a desirable normality. For example, dieting and disordered eating can be seen as self-normalising practices which reproduce female norms about the body (Bordo, 1990). Normalisation is at the heart of what Foucault saw as the modern form of power, 'a normalising gaze, a surveillance that makes it possible to qualify, to classify and to punish' (1975/1995, p. 184).

As was touched upon in the introduction, in the context of healthcare and medicine, Armstrong (1995) connects this self-normalising power to an increasingly strong approach to health and illness he calls 'surveillance medicine', and traces it to the beginning of the 20th century. It is specifically different from the clinical medicine carried out in hospitals, since it targets whole, seemingly healthy, populations, in attempts to 'bring everyone within its network of visibility' (p. 395). An important precondition of this new medical stance was its problematisation of the normal. In establishing the normal growth of a child, for example, the boundaries of normality could only be

identified relative to other children, not from a predetermined state of normality. The distinction that clinical medicine had drawn between normal and pathological was therefore dissolved. Today, surveillance medicine is characterised by the use of screening instruments, health-profile questionnaires and subjective health measures, examining potential experiences of ill-health in entire populations. This takes the reconstruction of normality a step further, because everyone is a potential patient, no matter how normal they feel. A new discourse has emerged in which an individual is considered at risk of different diseases, and therefore demands services such as screening and health-promotion activities. Patients themselves are primarily made responsible for the surveillance of risk factors. In this way, people discipline themselves to conform to the dominant guidelines in society's discourse about health at any one time. Nurses have acquired prominent roles in this work, which involves lifestyle changes and self-monitoring of health factors (cf. Kemppainen, Tossavainen & Turunen, 2012).

Professionals' construction of normality

Cheek (2000) claims that there are dominant ways of understanding what is appropriate and authoritative practice among healthcare professionals, and that these are taken for granted. Professionals are central in constructing normality, as it requires work from both professionals and care-seekers to maintain normality. The canons of normality have been widely accepted in society, and ensuring people conform to them has become the task of policemen, teachers, nurses, doctors, therapists and other normalisers (de Swaan, 1990). In their daily work, professionals see people not only as uncommon or atypical, but 'wrong', in need of 'correction' and guidance towards the normal and correct. I provide some empirical examples below to illustrate how healthcare professionals construct and use the concept of normality.

Patients who deviate from expected normality may be exposed to moralism in the form of health advice. In a study of professionals and patients at a health centre, it was shown that 'normal' patients were equated with 'easy' ones, where others were described as troublesome and difficult to handle (Fioretos, 2009). The difficult patients, categorised as 'complex', had symptoms which confused the staff. It was unclear to them why these patients came back regularly and showed no improvement. The nurses, who spent a great deal of time advising these complex patients about lifestyle improvements, had distinct ideas about what a good and healthy life should look like. Their knowledge and information were of a clear moral nature, indicating that taking responsibility for health involves conforming to certain moral values. The nurses' aim is to encourage the patients not only to desire, but also to choose, an active and healthy lifestyle. In the quest to embed these values, the nurses failed to see the complex patients' broader social context. Self-treatment might not apply to health problems caused by unemployment or economic insecurity for example. The nurses nevertheless saw it as their task primarily to help patients live according to accepted normality and to ensure they succeeded.

People can deviate from normality in different ways, such as through aesthetics. Sandell (2001) studied how the normal is created and recreated in the medical practice of plastic surgery. Plastic surgeons offer normalisation by medicalising a number of conditions, such as having only one breast following cancer treatment, burn wounds or breasts that are 'too' big. In a number of ways, these conditions medicalise anyone suffering from them, and make them deviant. In Sandell's study, the surgeons themselves rejected cosmetic reasons for surgery, emphasising instead patients' psychological suffering as the rationale for the procedure. Using Foucauldian concepts, Sandell concluded that the way these conditions in women are seen as deviation can be understood as 'the male gaze', masquerading as a medical stance.

Learning to be a nurse also involves learning and internalising certain norms. Assumptions about normality are built into the professional role as a caregiver, but they change when nurses are trained as midwives. Gleisner's study of midwifery education (2013) found that an important aspect of learning to become a midwife involves identifying and reflecting on norms. Norms about birth and feelings are major elements in learning the profession. The aim of a midwife is to ensure women experience a 'normal' birth, which means that students have to rethink the norms about pain they learned when they first became a nurse. In the normal birth trajectory, pain is natural and positive, at least up to a certain degree. If any deviation is detected, an important aim is to ensure the birth remains as normal as possible. Students also have to learn appropriate professional feelings in the role of midwife. Professional norms are thus both medical and emotional, and learning to approach and negotiate the normal is central for midwives-to-be.

The desirability of normality has been studied in situations which are characterised by something unknown. Bredmar (1999) explored midwives' awareness of the importance of patients feeling normal. In her research on midwives' support to expectant mothers, she identified that the midwives acted and communicated as if their main task was to transform the women's experiences of something 'unusual' during pregnancy into something that was 'normal'. The midwives indulged in a massive discursive effort to eliminate worry and anxiety from the women by constantly valuing and judging their examination results in terms of normality. It appeared as if the midwives feared that even conversations about anything that could be perceived as 'not normal' would develop ill-health in the women.

The boundaries of the normal or the healthy are often hazy, despite the frequent claim of scientific and medical objectivity. In communicating the meaning of abstract, quantitative test results, nurses use the recurring concept of normality in relation to numbers, since it

intuitively makes sense for patients (Adelswärd & Sachs, 1996). Test results can signal that a patient is at risk of something, such as a high cholesterol level indicating a risk of heart disease. Risk is a difficult concept to grasp, but talking about it in terms of normality seems to keep the world in order for both nurses and patients. By talking about test results as numbers, potentially face-threatening topics can be discussed neutrally, avoiding the moralism inherent in commenting on lifestyle choices. Instead of telling a patient that he is overweight, drinking too much or exercising too little, numbers and their relation to normal values can be a neutral way of communicating in terms of these issues.

Chapter 2. A paradox and a possible answer

> *[...] our persistent identification of being a "caring" professional inadvertently creates and maintains identity of color blindness (we treat everybody the same; caring nurses do not oppress). (Schroeder & DiAngelo, 2010, p. 247)*

The aim of this chapter is to connect the concept of the normal to healthcare professionals and how they encounter, treat and judge patients. The apparent paradox between professionals' ethical pathos and the outcomes can be understood in the light of norm criticism, a collection of pedagogic methods and tools originating in anti-oppressive and queer resistance theories.

Inequity in healthcare

Rhetorically, at least, equity is an uncontroversial ideal in nursing work, stipulated by law and addressed in international ethical guidelines in the following way:

> *The nurse advocates for equity and social justice in resource allocation, access to healthcare and other social and economic services. (International Council of Nurses, 2012, p. 2)*

> *Inherent in nursing is a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status. (International Council of Nurses, 2012, p. 1)*

Despite the fact that equity, social justice and dignity seem to permeate the ideals of how care should be provided, reality indicates examples of the opposite (see, for example, Baillie & Matiti, 2013). It is well documented that equity in healthcare has still not been achieved in many areas, such as issues involving patients' race and ethnicity (Ben, Cormack, Harris & Paradies, 2017; Fiscella & Sanders, 2016; Hall & Fields, 2013), social class (Gengler, 2014; Henshaw, 2001; Williams et al., 2015), gender (Holge-Hazelton & Malterud, 2009; Kent, Patel & Varela, 2012; Risberg, Johansson & Hamberg, 2009; Smirthwaite, Lundström, Wijma, Lykke & Swahnberg, 2016), lesbian, gay, bi, trans and queer (LGBTQ) identities (Fish, 2016; Kellett & Fitton, 2017; Lisy, Peters, Schofield & Jefford, 2018; Nhamo-Murire & Macleod, 2017; Paradiso & Lally, 2018) and generally across population categories in Sweden, for instance (Socialstyrelsen, 2011; Vårdanalys, 2014).

Of course, few healthcare professionals deliberately provide care in an oppressive or discriminatory manner (cf. Eliason, 2017). The reasons given for inequity in healthcare include economic and organisational conditions, but can partly be traced to the impact of healthcare professionals' implicit norms, values and prejudices in their encounter with patients (Spencer & Grace, 2016; Smedley, Stith & Nelson, 2003; Socialstyrelsen, 2015). Because we are not conscious of every norm that influences us, implicit attitudes can mean professionals act contrary to their moral beliefs and values. Even individuals who consciously espouse equity can play out stereotypes and prejudices in their interaction (Hall & Carlson, 2016). Research suggests that judgements which are taken for granted, or implicit biases, could lead to stereotyped judgements, for example (Hakimnia, Carlsson, Höglund & Holmström, 2015; Hall & Fields, 2013; Holmström, Kaminsky, Höglund & Carlsson, 2017), impaired communication between patient and professional (Hedegaard, 2014; Porter, 2005; Röndahl, Bruhner & Lindhe, 2009), moral judgement of patients (Fioretos, 2009; Roth,

1972) or even denying care (Tang, Browne, Mussell, Smye & Rodney, 2015).

There seems to be a contradiction between taking for granted a desire to do good, and implicit patterns of thinking and acting which may result in treating people and patients unfairly. The concept of norms can make sense of this contradiction, as norms involve deeply embedded cultural beliefs about the social world of which we are sometimes not even conscious (cf. Phillips, 2014). These beliefs affect people's interactions, attitudes and prejudices, and nurses and patients are no exception.

The construction of Others: a foundation for inequity

In all contexts, social norms set standards and establish paradigms that are sometimes difficult to change (cf. Wittmann-Price, 2004). Beliefs about who is normal and who is the exception result in privileges for some, and marginalisation for others. In a sociological context, the term 'Other' refers to differentiating discourses that lead to moral and political judgements of superiority and inferiority between 'us' and 'them', on the basis of some form of categorisation of identity (Dervin, 2015). Power is always involved in these processes. The term 'Other' can be used about groups which are traditionally marginalised in society, and which are *other than* the norm (Kumashiro, 2000, italics in original). Othering creates a boundary between different and similar, insiders and outsiders, and even actions with the best of intentions can lead to Othering. For example, 'xenophilia' is problematic as well as xenophobia. Appreciating the Other because of their Otherness rids the Other of the freedom to break free from stereotypes (Dervin, 2015).

Historically, by focusing on how Others are perceived and described, white, middle-class, European and American men have been projected as the baseline from which to judge everything which is seen as 'different' (Whittle & Inhorn, 2001). Early biology professor Ruth Hubbard (1990) highlighted the scientific interest in women in her illustration of the way they had historically been Othered and excluded from the 'human' norm:

> *Science or, rather, scientists – that relatively small group of economically and socially privileged white men with the authority derived from being scientists – have had an important share in defining what women's human, and more specifically female, nature is and then in defining what is normal for us to do and not to do, indeed what we can do and be. (Hubbard, 1990, p. 17)*

Hubbard's words show how those in dominant positions have had the power to define the knowledge about the Other which is taken for granted. Because of the close relationship between power and knowledge (Foucault, 1982), the people who are privileged enough to acquire authoritative positions in society have the opportunity to define what is true about less privileged groups. This knowledge will strengthen and confirm the positions and roles of different groups. Examples include Western scientists and physicians who developed gynaecological science in the 19th century to try and solve 'the woman question', and who were interested to discover that white middle-class women were sickly, weak, irrational, hysterical and less intelligent than men. Bredsdorff and Kjældgaard (2012) point out that the extent of the group afforded human rights has always varied, and that white men have taken it upon themselves to claim 'universal' human rights that, at different points in time, were not applicable to women, Jews or slaves.

Even though the legislation and rhetoric of anti-discrimination and human rights are strong in Swedish society, everyday talk, choices and reactions can mirror deeper norms and attitudes, signalling that some

people and their lives are more normal, right and righteous than others. There are norms that make some life paths and bodies possible and recognisable, so that these life paths and bodies are designated 'normal', with consequences for how we view ourselves and others (Martinsson & Reimers, 2010b).

The development of norm-critical pedagogy

In Sweden, the institutional view of normality as something static, desirable and essential has been challenged by the development of norm-critical pedagogy, a collection of pedagogic methods and perspectives which are critical to understanding the construction of power and privilege (Bromseth & Darj, 2010). Norm criticism is not only a form or a method, it is a normative theory with normative content (Theodorsson, 2018). Originating from anti-oppressive and queer theories (Butler, 1993; Freire, 1970/2000; Kumashiro, 2000), the term 'norm-critical pedagogy' was coined during the first decade of the 21st century. The inventors of the term wished to shed light on how social norms intersect to create power hierarchies and exclusion, and how this can be challenged through education. After its introduction, norm-critical pedagogy quickly became popular in Sweden, and has been applied as a practical and theoretical tool in several areas. One area which benefited from considerable norm-critical research, inspired by queer pedagogy, involved the ways schools produced and reproduced norms of gender and sexuality (Bromseth & Darj, 2010). It has since been extended into the field of higher education, broadening its perspective to include aspects beyond gender and sexuality (Bromseth & Sörensdotter, 2014; A. Johansson & Theodorsson, 2013; Kalonaityté, 2014; Kjellberg, 2015; Lekebjer et al., 2015), such as disability (Ring, Kristén & Klingvall-Arvidsson, 2019), product design (Ehrnberger, 2017), social resistance (Henriksson, 2017), diversity management (Holck & Muhr, 2017) and nursing science (Dahlborg-Lyckhage, Brink & Lindahl, 2018).

Norm-critical pedagogy, along with other critical pedagogic directions, takes its initial inspiration from Freire's philosophy of pedagogy, which aims to emancipate the oppressed (Freire, 1970/2000). Freire's work was directed at the illiterate, oppressed social class in Brazil. He saw the goal of education not just as teaching the illiterate how to read and write, but emancipating this class from their oppression. Language is knowledge in itself, and it is therefore impossible to access meaning by reading words alone – one must first read the world in which these words exist (Freire, 1997). Freire challenged educators to consider social norms as a primary factor in the education process, and pointed out the importance of respect for those who were to be educated. He considered it essential to respect their language, colour, gender, class, sexuality, intellectual capacity and creative ability, and to see students in their social and historical context (Wittmann-Price, 2004).

Educational theorist Kumashiro (2000) further developed Freire's ideas of education in order to work against different forms of oppression, making use of post-structural as well as psychoanalytic influences. Kumashiro claimed that a starting point for all anti-oppressive education is the insight that certain ways of being are privileged in society while others are marginalised. This insight can, however, result in very different pedagogies and educational policies being considered useful in counteracting this oppression. Kumashiro's studies outlined four main approaches in the quest for anti-oppression in educational contexts, all with their strengths and weaknesses. Two of them address 'Others' as deviant individuals, while two are interested in the very construction of the 'Others' (Kumashiro, 2000). They are described in the following. Here, it should be noted that there is no quintessential 'Other'. Hierarchies are quite contextual and can shift from time and place.

Education for the 'Other' addresses the physical and social school environment, where the aim of educators is to acknowledge and affirm

students' differences in identity and tailor their teaching to the specifics of their student population. Examples include creating 'safe spaces' in which Othered students will not be harmed either verbally, physically, institutionally or culturally, providing therapeutic help to harmed students such as support groups, and teaching in 'culturally sensitive' ways by incorporating minority students' home culture into classrooms, or being attentive to differences between how boys and girls think and evaluate. Schools need to welcome, educate and address the needs of all students who are marginalised and harmed by different forms of oppression. However, this approach mainly focuses on individual prejudice and harmful interpersonal treatment of the Other, ignoring other causes and manifestations of oppression. It also requires static definitions of Othered groups, and often fails to address students who are marginalised on the basis of more than one identity.

Education about the 'Other' addresses official, as well as hidden curricula. The assumptions behind this approach are that both privileged and marginalised students must be involved in knowledge about the Other, and that oppression will cease if students are more informed. This can either mean that specific units on the Other are included throughout education, or that lessons on the Other are incorporated across every subject in an ongoing way. The aim is to develop not only knowledge about the Other, but also empathy. This approach risks essentialising Otherness and consolidating its difference from normality, as though it were possible to learn about a single, definitive queer experience or a single, definitive immigrant experience. As a consequence, Othered students can be positioned as experts and seen as representatives of a certain group, e.g. asking a Muslim student about Muslim perspectives on certain matters. Another shortcoming of this approach is that there is not enough time in schools to provide adequate teaching on every culture, every norm and every identity.

Education which is critical of privileging and 'Othering' is different from the first two approaches in that change, as well as knowledge of the Other is of interest. The focus should not only be on how the Other is oppressed, but on the privileges of normality. In schools, this means that all students, whatever their identity, should be given knowledge about the structural and ideological processes by which some are Othered and others are normalised in society. Normality and Otherness are cultural, and contested, constructs. This knowledge is needed to develop a critical consciousness, which in turn can empower students to challenge oppression. A teaching strategy might involve unmasking the privilege of certain identities and illustrating how invisible they are, such as white or male privilege. Students need to learn about themselves and their own possible privileges, to see that they may themselves be contributing to oppression. However, this kind of education often fails to acknowledge that not all members of an oppressed group experience oppression in the same way, and that awareness of processes does not automatically lead to change or action. The approach can also be criticised for being normative, because it replaces certain frameworks of looking at the world with other, 'correct' frameworks, and assumes a rationality that knowledge will be transformed into consciousness and finally into action.

Education which changes students and society is an approach where language use is central. The way in which language is used not only mirrors, but also constructs the world around us. Oppression is therefore considered to originate in and affect discourse. For instance, iteration of stereotypes in education is a harmful, potentially oppressive, practice. From this point of view, it follows that harmful discursive practices should be replaced with different ones. However, instead of prohibiting harmful language or creating critical awareness of certain terms, a more effective strategy is to alter it. A prominent example of this form of change involves the term queer, which now carries a sense of self-empowerment, rather than hate. It is important that students learn to be dissatisfied with what is being said, and

instead to participate in the ongoing construction of knowledge. They should always take into account 'what is not said'. In strategies that aim to effect change, psychological notions of the unconscious are important in terms of understanding resistance to change. People tend to resist knowledge which disrupts what they already know. The goal of this approach is not to outline a particular way of thinking, but to encourage students to think differently, informed by anti-oppressive theories.

Norm-critical pedagogy has largely been inspired by the third and fourth approaches, sharing Kumashiro's criticism of processes which ignore or essentialise oppression. Henriksson (2017) defines norm criticism as a recent development in queer resistance, which challenges norms from within the seats of power themselves. Challenging norms is a political as well as a pedagogic project (Martinsson & Reimers, 2010a), and the overarching ambition of norm-critical pedagogy is to create sustainable awareness of societal power relations that can be transferred to situations outside the classroom (Kalonaityté, 2014). Instead of targeting those perceived as norm-breakers, 'the Others', the focus moves to those considered norm-bearers, to that which is taken for granted (Lekebjer et al., 2015), and to normative 'subtitles' in educational situations (Kalonaityté, 2014). This helps develop a more inclusive educational space which, instead of aiming for empathy or understanding for the Other, focuses on exploring which actions and assumptions within ourselves construct and cement exclusion (Lekebjer et al., 2015).

A norm-critical approach is not a fixed body of knowledge and skills. Instead, it is a perspective, a way of thinking based on being dissatisfied with what is being learned and said, and what is known (cf. Kumashiro, 2000). At the same time, norm criticism is normative, as pointed out by Theodorsson (2018). Taken together, the norm-critical principles laid out in this chapter, building on theories of anti-oppression, can be used as tools in working towards change. They

offer a dynamic approach to the complexities of oppression, and avoid using pre-packaged answers to questions of 'what' and 'how'.

The pedagogy of the norm-critical framework can be interpreted in a broad way to include a number of methods and perspectives related to learning, beyond classroom situations. In all contexts, however, personal reflection among participants is essential. To effect a change in the rigid construction of normality and Otherness as opposites and hierarchies, the values and beliefs a person currently holds must be transcended. We need to engage not only in self-reflection, but in self-reflexivity. By scrutinising how our own involvement in oppression has a bearing on our own sense of self, it is possible to change how we read Others and ourselves (Kumashiro, 2000). Thus, norm-critical work is deeply reflexive, because without it individuals cannot change, and continue to reproduce internalised views of the normal and the privileged.

Tolerance: a coping mechanism for the majority

As discussed, where educational approaches focus on emphasising the Other, the privileges which come with being normal tend to be masked. These were mainstream forms of anti-discriminatory teaching in Sweden before the growth of the norm-critical perspective, and have been termed 'tolerance pedagogy' (Bromseth & Sörensdotter, 2014). The fact that tolerance has negative connotations here might sound strange. In the public debate, 'tolerance' is generally seen as positive, a characteristic to be proud of, which is significant for modern, Western values (Blommaert & Verschueren, 2002), and perhaps Swedish values in particular (Martinsson & Reimers, 2010a). It has, for instance, been used as a way of differentiating a civilised west from a barbaric Islam (W. Brown, 2009). Generally, tolerance signals generosity and acceptance towards individuals and groups outside society's majority norms.

The problematic aspects of tolerance include its function as a form of permission. The term signals that a tolerant majority 'allows' the minority to lead the kind of lives they wish, and implies that the majority oppresses their repulsive feelings for the minority. Tolerance as a form of permission (Bredsdorff & Kjældgaard, 2012) is the kind of tolerance most norm-breakers have faced. It signals that something is deviating from the norm, and that most people find it disturbing but accept it anyway. From this point of view, tolerance is only a strategy for coping, not a strategy for change (W. Brown, 2009). Tolerance of LGBTQ people, for example, does not include these people in society, it simply points out their Otherness and the generosity of the majority people who allow them to exist. Browne and Reimer-Kirkham (2014) highlight the paternalistic position of the well-meaning majority in saying that 'the spotlight on the needy and oppressed tends to locate us in a position of authority as we deem who is eligible for our social justice efforts' (p. 28). In other words, tolerance is the act of distributing rights to others which are taken for granted for oneself (Eriksson, 2014). Examples of this form of authority include a bill that was passed in the Swedish parliament in 1973, in which it was stated that homosexual cohabitation 'is, from society's viewpoint, a fully acceptable way of living' (Sveriges Riksdag, 1993). At the time this was a very progressive statement. From a norm-critical perspective, however, the statement clearly shows the Othered position of homosexual people. Homosexuality is approached as an object for society's acceptance and tolerance, without interfering with dominant norms (see, for example, Bromseth & Darj, 2010).

The Other has, of course, long been an object of discourse in the Western world (Blommaert & Verschueren, 2002). 'We' reconstruct the 'Other' in terms of our own categories, expectations, habits and norms. We set up rules for the Other to follow in order to be tolerated. In this way, the Other is not affirmed, but conditionally allowed, despite being unwanted, different or deviant. Thus, tolerance is a strategy for regulating aversion and a tactic for exerting power. It even

justifies violence towards those who are not as tolerant as 'us' (W. Brown, 2009).

As suggested by Kumashiro (2000), tolerance essentialises those seen as the Other. They are seen as eternal, incapable of change, condemned to remain different. Brown (2009) agrees with this, saying that through discourse, tolerance reframes the differences between majorities and Others, such as racial, ethnic or sexual identities, as differences of essence rather than differences constructed by historical context and experience. This, in turn, prevents social change of norms and normative assumptions. If the education of future nursing professionals is characterised by tolerance, it contributes to deep-set beliefs about normality and Otherness, with a possible impact on the treatment of patients.

It is important to address the conventional attitude of 'tolerance-as-permission' in order to understand the contribution of norm criticism. However, a less critical interpretation points out that tolerance is not just used in a paternalistic and patronising way, but can also guide respectful relationships (Bredsdorff & Kjældgaard, 2012). A society must offer space to a variety of lifestyles, values and opinions, even if not everyone understands or agrees with them.

The norm-critical case for this dissertation

The idea for this dissertation originated in a norm-critical project within a nursing education programme, initiated at the Department of Health Sciences at University West, Sweden, in 2014. The project set out to develop and integrate norm-critical perspectives into the nursing programme in the department, thus better preparing nursing students for their professional responsibility of providing equitable healthcare. The first activities involved improving the teachers' competence in matters regarding norms, normality, power and

privilege, as well as their importance for healthcare in general, and for nursing care specifically. The department established a 7.5-credit course called ‘Norm-Aware Caring’, open to all teachers, as well as follow-up seminars and an expert group at the department. The department also embarked on a revision of all course curricula, literature lists and examinations. Since the onset of the project, goals related to raising awareness of norms have been incorporated into the department’s operational plan, and a clinical learning centre has been developed with a norm-critical profile.

Chapter 3. The need for anti-oppressive approaches in nursing and nursing education

> *She [Florence Nightingale] defied convention, stepping out of her class and gender norms to embark on a crusade which helped to turn nursing into a scientific and secular profession. (Rafferty & Wall, 2010, p. 1063)*

The aim of this chapter is to provide a brief historical context to the values of the nursing profession, and to set out how nursing education in Sweden is organised. It will also introduce anti-oppressive perspectives, why they are needed, and examples of approaches that have been used in the emancipatory development of nursing education programmes.

Some nursing history

The emergence of nursing as a profession during the 19th century was characterised by highly gendered understandings of caregiving (Tierny, Bivins & Seers, 2019). Florence Nightingale's first version of her influential publication *Notes on nursing* targeted a female audience: wives, mothers, daughters and female servants who had responsibility not only for caring for sick people in the home, but also for cleanliness (Davies, 2012). Published in the United Kingdom in 1859, it had already been translated into Swedish by 1861.

Two conditions were especially important for the development of the nursing profession in Sweden. The first was the development of biomedicine and the subsequent institutionalisation of healthcare, which led to an increased need for labour. The second was

'the woman question', the debate regarding women's place and mission in society, and their access to education and work (Andersson, 1997). With the emergence of nursing as an occupation, healthcare was one of a limited number of areas where women had the opportunity to work.

Lutheran norms also had a strong influence on Swedish societal structures in the 19th century. These shaped the view of women in caring and helping work. When they were involved in caring and helping in their family and in society, women were considered to be following their specific female 'calling'. By serving the ill and the poor, they could serve both God and their husband (Andersson, 1997). Unlike the bourgeois women involved in philanthropy, nurses were mostly unmarried women from the middle class. The moral instinct that women were considered to have was seen as a qualification for care work, and the importance of personal character, such as self-sacrifice, was highlighted when a woman was considered for the profession (Andersson, 1997). Central to this transition of nursing from trade to profession were visions of a vocation steeped in caring, sympathy and selflessness (Tierny et al., 2019). Nightingale proposed that 'you cannot be a good nurse without being a good woman' (K. Smith & Godfrey, 2002). Fealy (2004) points out that historically 'the good nurse' had to be a certain kind of person, and that 'feminine qualities' were highlighted as important in carrying out the nursing role.

From the turn of the 19th century onwards, nursing was more and more committed to a professionalisation process, where a need for empathy, emotional labour and self-sacrifice linked it to moral and religious virtues (Tierny et al., 2019). Working as a nurse gradually became a profession like any other, though the ethical aspect was used to demarcate it from other professions. Today, it seems that nursing continues to suffer from the influence of traditional values and cultural

or social norms with respect to gender and professional status (ten Hoeve, 2018).

Nursing education in Sweden

Education is the main socialising arena for future professionals, and shapes students' attitudes, values and norms. In Sweden, nursing training began in 1851, after it had been accepted as a profession for unmarried women. It gained academic status in 1977 (Furåker, 2001). The outcome of the three-year undergraduate nursing education is twofold, as students receive both a professional qualification as a registered nurse and a Bachelor's degree.

Swedish legislation governing higher education consists of The Higher Education Act and The Higher Education Ordinance. The Act formulates the foundational goals for all graduate programmes within Swedish higher education (Svensk författningssamling, 1992:1434). The Ordinance controls courses, course syllabi and course examinations (Svensk författningssamling, 1993:100). A course is the most important unit of higher education, and universities are free to organise the education within given frameworks in terms of time requirements and course credits.

The three-year undergraduate programme comprises theoretical education and clinical practice. Each university or university college has some flexibility in how they choose to design their educational programmes, as long as national goals are met. In fact, universities and university colleges are continuously evaluated to verify whether they are actually complying with these goals. Each local education programme is further governed by an education plan which provides an outline of the three undergraduate years. For each course within the programme, a syllabus must be provided containing course goals, primary course content and course literature.

Since the reform of Swedish higher education in the 1990s, two features have developed: the acknowledgement of *competence* as an important outcome and the establishment of a *system of values* in educational programmes. Competence is now described as central to higher education. Students are expected not only to assimilate knowledge, but to implement what they know (Furåker, 2001). In addition, the underlying system of values has acquired a distinct role in higher education programme design. In nursing education, the most distinct values are 'humanist', 'Christian' or 'existential'. According to Furåker (2001), this marks a departure from biomedical science as the foundation of nurses' academic schooling. Institutions are more and more eager to brand their programmes as unique in some way, leaving more room to focus education on issues such as ethics or public health. Overall, nursing education has developed from apprenticeship training to becoming an academic education with demands in terms of critical thinking (see, for example, Carlsson, 2010).

Anti-oppressive traditions in nursing

Long before the framework of norm criticism was introduced in Sweden, critical nursing scholars have used the concepts of social justice and emancipation at an international level to discuss oppressive practices and their effects in terms of inequity. These approaches take nurses' social responsibility into account, and view health and care inequities as expressions of power. The emancipatory nursing tradition addresses the binaries of privilege and oppression in patient encounters and society, and has its theoretical roots in critical social theory as well as feminist theory (Kagan, Smith & Chinn, 2014; Wittmann-Price, 2004). Emancipation is a concept used in political philosophy. In healthcare, emancipatory strategies are usually linked to empowerment in both patients and professionals, which allows and encourages them to identify, challenge and transform oppressive

practices (Perron, Rudge & Gagnon, 2014). Emancipatory approaches in nursing emerged in the 1980s, with the aim of questioning structures of oppression and hierarchy. Kagan and Chinn (2010) state simply:

> *We need to recognize our own repressive behaviour toward others and our own intolerances and prejudices. (p. 42)*

A related concept is social justice, which aims to mitigate the negative health effects of widespread inequity (Browne & Reimer-Kirkham, 2014). Justice is, of course, a concept that can be analysed thoroughly and used in many different contexts. In this dissertation, it is sufficient to note that 'social justice' is rarely used in the Swedish nursing literature and that 'equity' is more common wording in terms of discussing disparities of different kinds in healthcare. Along with anti-oppression theory, social justice seeks to address structural inequities and divisions experienced by patients (Hutchison, 2015). In Wilkinson's view (1996), social justice includes the public health goals of equal distribution of health in society. The social justice agenda has been an integral aspect of nursing, healthcare services and nursing practices for a long time in nursing history (Boutain, 2005; Browne & Reimer-Kirkham, 2014) and, as noted previously in this text, the concept is included as a goal for advocacy in the international ethical guidelines for nurses (International Council of Nurses, 2012).

Emancipatory perspectives in nursing education

Nursing professionals should be concerned with power, because power is a dynamic that rules everyone's life (Kagan & Chinn, 2010). However, this is a not a perspective which has traditionally been incorporated into nursing education programmes. For decades, nursing education has suffered from the authoritarian constraints of power-blind models, leading to calls for emancipatory forms of pedagogy which can address oppressive social structures within the larger

context of nursing (Harden, 1996; Romyn, 2000). Education in itself can be seen as a practice involving social justice, and more attention needs to be paid to teaching social justice from multiple viewpoints in nursing education programmes (Browne & Reimer-Kirkham, 2014; MacDonnell, 2014; Reichlin, Peltier, Raether & Polonsky, 2019). To avoid causing harm in encounters with patients, nurses must be aware of the social inequalities and biases that have historically affected people from different groups who are seeking care. Awareness of a person's own biases and assumptions is also essential, as well as awareness of the power (im)balance which is necessarily present in any professional encounter. Over the years, a large body of research has criticised the marginalised positions given to some perspectives in healthcare education, and has pointed out that the tools nurses need in their practice are not always given to them during their education. Students who are trained to address oppression and marginalisation will carry this awareness and reflexivity into their work placements and future practice, and will continue to be advocates for their patients (Kellett & Fitton, 2017).

Anti-oppressive nursing education has been addressed through a variety of perspectives, several of which are inspired by Freire's work. The strategy of problematisation, a way of 'uncovering reality', has been highlighted as an important aspect of emancipatory education (Alves Rozendo, Santos Salas & Cameron, 2017). As nurses or nurse educators, it is easy to fall prey to dominant discourses preventing us from posing critical questions – when instead, reality should be questioned, queried and problematised. Other examples include culturally responsive teaching, which builds on Freire's insights about how to create empowering learning environments (Day & Beard, 2019), and the critical caring pedagogy proposed by Chinn and Falk-Rafael (2018), which is informed by Freire's concepts of praxis, reflection, and action that leads to change.

Assessing the 'success' of emancipatory education

Falk-Rafael et al. noted as early as 2004 that enthusiasm for the empowering potential of critical pedagogies in nursing literature could be contrasted with the lack of empirical evidence for their effectiveness (Falk-Rafael, Chinn, Anderson, Laschinger & Maxson Rubotzky, 2004). The use of self-report measuring scales is a conventional method of highlighting the effects of projects. Several scales, instruments and tools have been constructed and validated in order to measure respondents' attitudes towards aspects of 'normality' and 'differentness'. Examples include scales that measure potential negative attitudes towards, and stereotypes of disabled people (Ten Klooster, Dannenberg, Taal, Burger & Rasker, 2009), older people (Sarabia-Cobo & Castandedo Pfeiffer, 2015; Söderhamn, Gustavsson & Lindencrona, 2000), cultural affiliations (Marzilli, 2016; Milne, Creedy & West, 2016) and 'atypical' patients in Swedish healthcare (Holmström et al., 2017). Also, scales have been developed to assess more general phenomena, such as discrimination towards racial minority groups and women (Ponterotto, Potere & Johansen, 2002) and implicit biases (Greenwald, McGhee & Schwartz, 1998).

Perspectives related to culture, race and ethnicity

Perhaps the strongest anti-oppression theme found in international nursing literature involves culture, race and ethnicity. Anti-racist discourse has been present in nursing education and science since the early 1990s (Schroeder & DiAngelo, 2010), partly as a response to the popularity of cultural competency, which has been criticised for its simplicity among other things. It asks students to do little more than memorise lists of characteristics of people who are most unlike themselves, but does not address the institutional structures that contribute to racism, bias and exclusion (Wear, Zarconi, Aultman, Chayette & Kumagai, 2017). Teachings on culture in nursing education have paradoxically reinforced nurses' complicity with

imperialist practices, essentialism and making difference seem exotic, (Browne & Reimer-Kirkham, 2014). To avoid the pitfalls of cultural competency, anti-racist pedagogic models for nursing education have been suggested, building on the theoretical base of Freire's critical pedagogy (Blanchet Garneau, Browne & Varcoe, 2017). The aim of anti-racist pedagogy is to provide students with the ability to reflect on the ways in which power relations are embedded into their own lives, as well as the lives of others (Hassouneh, 2006). Cultural safety, a concept which originated in the relations between Maori and British colonialists (Woods, 2010), has been proposed as a framework for facilitating safe educational spaces for everyone who is Othered by dominant perspectives and structures (Aboriginal Nurses Association of Canada, 2009). In Australia, it has been used in cultural training programmes for nursing academics to improve the educational environments for indigenous students (Milne et al., 2016). In the U.S., a strategy of culturally responsive teaching has been suggested in nursing education. This aims to empower different voices in healthcare settings which are often silenced (Day & Beard, 2019).

Feminist perspectives

When feminist theories started to make their way into the field of nursing, it was the starting point for the development of more critical perspectives within the field. A number of researchers have advocated feminist approaches in nursing education, as these approaches involve a critique of traditional models of education (Chapman, 1997; Falk-Rafael et al., 2004; Lamont, 2014; MacDonnell, 2014; Welch, 2011). Researchers have suggested the need to emancipate nurses from sexist oppression and to reconceptualise nursing curricula, ideally reframing women's health (Bent, 1993; Morse, 1995). Feminist pedagogy can create a more democratic classroom and be a means of changing nursing education curricula (Welch, 2011), as it can provide teachers with tools for critical appraisal, and for reflecting on what they teach, how they teach, and the fact that who they are will influence how they

teach (Lamont, 2014). Critical feminist methodologies in the classroom can show students the interrelations between structural influences and individual experiences (MacDonnell, 2014). Promoting a feminist approach which highlights gendered, oppressive structures can encourage students to take a stance against the oppression of different groups within the healthcare environment (Welch, 2011).

Sexuality perspectives

Sexual orientation impacts health in a number of ways, yet healthcare services are not adequately meeting the needs of lesbian, gay, bisexual and trans patients (Somerville, 2015). One explanation for this is the heteronormativity present in nursing education and practice (see, for example, Fish, 2016; Kellett & Fitton, 2017; Röndahl, 2011). A study investigating attitudes among nursing students in Sweden shows that they occasionally express homophobia (Röndahl et al., 2009). Heteronormative assumptions still pervade society as well as healthcare, and can disadvantage lesbian women (Legere & MacDonnell, 2016) and gay men (Connolly & Lynch, 2016), as well as transgender people (Kellett & Fitton, 2017). Furthermore, nursing students have suggested that they find caring for LGBTQ adolescents uncomfortable, which has led researchers to suggest that self-awareness and LGBTQ knowledge should be highlighted in educational contexts (Richardson, Ondracek & Anderson, 2017). Recently, there have been calls for curriculum development in terms of transgender issues, because gender diversity is one of many factors that impact patients' health and wellbeing (Kellett & Fitton, 2017). Important aspects to address in what Culley and Haigh (2016) call 'diversity and awareness training' include trans-inclusionary issues. Cultural safety has also been proposed as a viable and appropriate framework for addressing and supporting transvisibility and gender diversity in nursing education (Kellett & Fitton, 2017). This kind of framework can contribute to creating a new normal grounded in reflexivity and respect, recognising the diversity of the population. In

creating supportive spaces for critical dialogues, attention should be directed to both the content and the process of pedagogy, because of their 'potential to disrupt dominant heteronormative discourses and build more inclusive educational spaces' (MacDonnell, 2014, p. 274). O'Brien and Ellis (2016) have emphasised the importance of embedding an understanding of LGBTQ issues in professional healthcare education, and McCann and Brown (2018) show that the undergraduate health curriculum contains examples of inclusion and integration of the health needs and concerns of a range of sexual and gender identities. However, it is not only patients' sexual identity which requires attention. There is also a need to develop an understanding of hidden and contextual issues pertaining to nurses who identify as lesbian, gay, bisexual or transgender (Younas, 2019).

Intersections between forms of oppression

Additions to the above examples of oppressive structures include ableism, ageism and classism. Furthermore, the intersections between different forms of oppression must be considered, as the above-mentioned structures do not operate in isolation. A number of different foundations for identity need to be taken into consideration in terms of how the social world is constructed (Crenshaw, 1991). An intersectional approach moves beyond examining individual factors one by one, and focuses instead on relationships and interactions between categories such as socioeconomic status, gender and race (Kapilashrami & Hankivsky, 2018). This is not to say that all oppression functions in the same way, or that all social categories are homogenous. There are important differences within population groups, and oppression arising from norms of 'whiteness', for example, may be quite different from oppression arising from norms of sexuality. Nursing professionals must learn to answer to the needs arising from this complex world, and intersectional analyses aim to map out, and therefore target, inequities with greater precision (Kapilashrami & Hankivsky, 2018).

At the heart of reasoning about oppression is the complex concept of power, which should not only be understood in the sense of domination. The intersectional theorist Crenshaw has pointed out that it is common to view identity categories merely as 'negative frameworks in which social power works to exclude or marginalize those who are different' (Crenshaw, 1991, p. 1242). From the point of view of this perspective on identity categories, the objective for someone promoting the emancipation of oppressed people is to empty these categories of their significance. This involves overlooking the power embedded in belonging to a particular identity. In line with Foucault's reasoning about power as productive, Crenshaw suggests that the social power of delineating difference can be the source of social empowerment, strength, community and intellectual development, and should not be ignored in an attempt to diminish the importance of identity.

Chapter 4. Rationale and aims

Study rationale

‘The normal’ is a powerful concept in every society, with consequences for anyone (or anything) not defined as normal. Healthcare professionals are not excluded from the power of normality. Historically, ‘the normal’ has influenced nursing, and still does so today. It has influenced the way professionals encounter, treat and assess individuals and patients.

Because nurses’ values, prejudice and norms may influence their provision of care, it is important to raise awareness of these issues in the early stages of their education, the period in which students are first socialised into their professional role. Education is the main socialising arena for future professionals, and nursing education has been criticised for not sufficiently addressing notions of oppressive norms, equity and social justice. Previous studies suggest that there is a knowledge gap to be filled in terms of research on anti-discriminatory and inclusionary educational approaches, and that many things are taken for granted in healthcare practice. Unconscious expectations about ‘the normal’ among professionals may unintentionally contribute to inequitable care across groups, and to perpetuating a belief that, as a caring profession, nursing automatically ‘treats everybody the same’.

The case that is studied in this dissertation set out to develop and integrate norm-critical perspectives within a nursing education programme at a Swedish university college. No previous research has explored the development of norm-critical content, knowledge and competence in a healthcare education context. Hence, the knowledge contribution of this dissertation is important in considering the design of future nursing education programmes, as well as for norm-critical work in similar contexts.

Aims of the dissertation

The overall aim of the dissertation is to describe and scrutinise norms and normality in a healthcare education context from a norm-critical perspective. A further aim is to explore how a norm-critical perspective on nursing education can contribute knowledge to existing fields of critical inquiry.

Specific aims are:

- To describe the norms underlying central documents and texts in education
- To explore how teachers understand their own introduction to the norm-critical knowledge field
- To explore the views on norms and norm-breaking which students carry with them through their education
- To develop an instrument by which norm criticism can be operationalised and assessed

Chapter 5. Design, material and methods

The aim of this chapter is to give an overview of the designs, materials and methods used in the four studies. The concept of discourse, and its significance for the construction of different views of the world, was introduced in Chapter 1. It builds on the assumption that language is not a mirror but a game, and words obtain meanings through their use in these games (Wittgenstein, 1953/1976). In a constructionist view, language is constitutive, the living of life itself, and this view has guided the overall approach of this dissertation work. Different types of design, materials and methodology were used in the studies, with an emphasis on analysing spoken and written language (studies I-III). However, one study (study IV) also involved statistical methods. For an overview, see Table 1.

Participants and data-production methods

Study I: Selecting documents and literature

The aim of the first study was to explore whether and how norm-critical perspectives were reflected in the formal documents and literature of nursing education. The objects of study were main documents, including course literature which formed the basis of the nursing programme at University West. More specifically, the documents selected for analysis were (a) the national goals for the nursing degree as stated in the Ordinance for Higher Education, (b) the education plan for the nursing programme established by the

Table 1. Designs, materials and methods used in the dissertation.

	Design	Participants/ study objects	Data production method	Data analysis method
STUDY I	Cross-sectional document analysis design	Course curricula, higher education ordinance, course literature (n = 72)	Retrieving documents online or from library	Thematic analysis
STUDY II	Cross-sectional interview design	Teachers in nursing programmes (n = 20)	Focus group interviews	Critical discourse analysis
STUDY III	Cross-sectional survey design	Nursing students (n = 154)	Written statements in response to open survey questions	Discourse analysis
STUDY IV	Instrument-development design	Expert panel (n = 3) Nursing students (n = 546)	Norm-critical literature Questionnaires with Likert-scale responses	Thematic analysis Confirmatory factor analysis

department, (c) the 17 course syllabi which directed each course in the programme and (d) all 53 mandatory literature sources that were specified in the selected documents. These are texts which teachers work with constantly, and with which they need to be familiar. All documents were retrieved online or from the university college library. Although the analysis was carried out in 2017, documents were chosen which were valid in 2014, in order to obtain a glimpse of the dominant perspectives *before* the norm-critical project was set up in the department.

Study II: Conducting focus-group interviews with teachers

The aim of the second study was to describe discourses underlying nursing teachers' talk about their own norm-critical competence. The participants were teachers in the department's nursing programme. Focus-group sessions were used for data production. This is a research technique which collects data through group interaction on a topic determined by the researcher (Morgan, 1996). Groups interact, and the moderator has an important role in guiding this interaction. The interaction in itself is a source of data and can provide good opportunities for investigating 'complex behaviors and motivations' (Morgan, 1996, p. 139), as the participants not only ask each other questions, but also explain themselves to each other.

This method was chosen because of the interest teachers showed in interaction and communication in terms of norm criticism after they had completed the course 'Norm-Aware Caring'. As noted by Curtis and Redmond (2007), focus groups are the preferred choice of method where researchers are interested in processes of joint construction of meaning about a topic.

All teachers were invited to participate in the study after they had taken the course, which included basic knowledge about norm-critical perspectives in health care and education. Out of 33 course

participants, 20 took part in one of the five focus-group interviews (in late 2014 or early 2015). Sessions lasted 45–90 minutes and took place in workrooms at the university. I guided the five sessions, using an interview guide which covered questions on whether and how the course had given the teachers new knowledge and insights (see attachment I). All groups were engaged by the questions, which prompted interaction and discussion. The sessions were recorded and transcribed by me.

Study III: Asking for students' written responses to open survey questions

The aim of the third study was to explore constructions of norms and normality among nursing students. The participants were nursing students (including social psychiatric nursing students) from terms 1, 3 or 6, or in their specialisation year. The empirical material was collected in 2015 and 2016 (as part of the data collection for study IV). Five student classes were approached by me or a researcher colleague at the beginning or end of a lecture, and the students were asked to respond to a 46-item survey on norms and normality. At the end of the survey, they were asked to answer two open questions, which were the source of data for study III. Open questions refer to questions which had no pre-formulated response alternatives: (1) *Briefly describe what you perceive norms to be, in general or in your future profession*, and (2) *Do you have any personal experience of breaking norms?* The open questions formed the empirical material for study III. Out of the 222 surveys distributed, 214 were returned, and 154 of them contained responses to at least one of the open questions. All the hand-written responses were transposed into a Word document by myself.

Study IV: Constructing and distributing surveys to students

The aim of the fourth study was to develop a valid and functioning scale for measuring norm-critical awareness. The same groups of students participated as in study III (data for both studies were collected through the same survey). Purposive sampling was used, with the aim of obtaining a variation in the participants' experience of the nursing programme (Polit & Beck, 2008). Participants also included an expert panel of three academics, a group of pilot study students, and a 'think aloud' student panel.

The process of constructing an instrument started with developing an item pool. It was generated inductively with the purpose of capturing central norm-critical principles. Key literature on norms and norm-critical pedagogy was read closely by a member of the author group. Through thematic analysis of this literature (Braun & Clarke, 2008), 45 items were formulated, distributed over six identified themes. Items were reviewed by an expert panel (n = 3). The experts had extensive theoretical knowledge about issues related to norms and normality. They evaluated content, accuracy and wording of the items. Revisions were made according to the experts' judgements, and the number of themes was reduced to five (*Function*, *Consequence*, *Identity*, *Resistance* and *Learning*, with the preliminary theme *Power* integrated into the others). A five-step Likert assessment was used for each item, ranging from 'Total disagreement' to 'Hesitant/Don't know' to 'Total agreement'. Thereafter, two pilot studies (n = 110 and n = 221) were carried out in nursing classes at the university college in order to check the readability and level of understanding of the items. The students left considerable written feedback, signalling that many items were too difficult to understand. Following this, items were reformulated in simpler language.

To allow more in-depth discussions about the revised items, a 'think aloud' session (Tutticci, Lewis & Coyer, 2016; van Oort, Schröder & French, 2011) was held with nursing students (n = 6) who studied the

last term of the nursing programme. The instrument was handed out to the students about one week in advance of the session, together with two questions for each of the items: (1) *What do you think we want to know by asking this question?* (2) *Is there another way to formulate it?* Three researchers, including myself, participated in asking the questions and taking notes to capture the students' reflections. Final revisions were made, taking the conversation into account.

As 46 items were considered too many for an effective scale in practice, a reduction procedure was carried out. The scale needed to be balanced so that an equal number of items were included in each dimension. This would improve the usefulness of the scale if it was used as a set of subscales with a summary score. Out of a total of 222 surveys distributed, 214 were handed in by students, of which five were blank. 209 forms (94%) were included in the statistical reduction analysis.

Data analysis methods

Study I: Analysing documents and literature

Thematic analysis was used as presented by Braun and Clarke (2008), together with Bowen's (2009) approach to document analysis. The selected documents were read in their entirety. The 53 literature titles were explored by reading the preface and list of contents to obtain an idea of the perspectives which were represented and sections which should be read in their entirety. From the entirety of these data sources, phrases were extracted that contained concepts involving central tenets of the theoretical framework of norm criticism, such as 'gender equality', 'culture', 'power' and 'prejudice'. A search was also conducted for passages which included any of the identity terms used in the definition of 'equitable healthcare' specified by the Swedish Board of Health and Welfare: age, gender, disability,

education, social position, ethnic and religious background, and sexual identity (Socialstyrelsen, 2011). All selected excerpts of text were coded, that is, they were given labels which referred to the most basic element of the data, thus making it possible to organise the data into meaningful groups.

During coding, aspects were identified to form the basis of themes across the data set, the themes constituting patterns within the data which captured something of importance to the aim of the study. Preliminary themes were formulated by analysing the codes. This involved considering the broader themes they might form and their relationship to each other, as well as reflecting on their different levels of abstraction (Braun & Clarke, 2008). Finally, the themes were refined. Internal homogeneity and external heterogeneity were considered to ensure consistency throughout the analysis. I reread the entire data set to verify that the thematic map fit the data, and that no selected data had been missed or misplaced. My aim was to ensure rigour in coding, analysis and writing, including paying sufficient attention to each data item in the coding process, making sense of data rather than paraphrasing it, and using language and concepts consistent with the epistemological position of the analysis.

Study II: Analysing focus-group data

Critical discourse analysis (CDA) was used as a framework for analysing the data. CDA is an interdisciplinary approach to the study of text, which aims to unveil how social domination is presented in language use (Fairclough, 2015). It stems from the intellectual traditions of discourse studies, feminist post-structuralism and critical linguistics (Rogers, Malancharuvil-Berkes, Mosley, Hui & Joseph, 2005). The main assumption is that language use is a form of social action. Language constitutes social life and its inherent power relations, but at the same time, social relations constitute language. The idea that language represents something essential, an experience

within the person, is rejected in line with constructionist epistemology.

However, there is no given analytical procedure for conducting a CDA. The following procedure, inspired by Schofield et al. (2012), was therefore established for study II. The transcribed interview sessions were read repeatedly by myself to identify the main discursive constructions. Statements which described the teachers' views on norms and norm criticism in nursing education were highlighted and copied into a separate document. Patterns of meaning in the statements were noted, giving rise to preliminary themes. Each statement was analysed for the following linguistic properties: *key words*, which illustrate the knowledge and beliefs of the text producer; *metaphors*, which have ideological associations and imply certain ways of dealing with things; *unclear agency*, which can be used to obfuscate agency, causality and responsibility; *pronouns*, which signal different relational values; and *modality*, which refers to speaker authority and expresses the likelihood of something. Relational modality expresses the authority of one participant relative to others, while expressive modality describes the writer's authority with respect to the truth. The discursive practice of the statements was then analysed. Discursive practice comprised the teachers' reflections on the knowledge which constituted their actual teaching practice. Together with the textual analysis, the discursive practice helped us elaborate on or disprove the discourses underlying the teachers' talk. Finally, the reasons for the unique manifestations in the discourse were explored by connecting them to the broader theory of the social context.

Study III: Analysing written statements

Gill's (2000) outline of a discourse-analytic process was followed to analyse the students' statements. Their responses made up a corpus of 5876 words, and I read this a number of times to familiarise myself

with the text. Secondly, all text which was relevant to the study aim was selected and highlighted. This step of the analysis is time-consuming, as it can take a while for the phenomenon of interest to become clear. The understanding of what should be selected for analysis may change repeatedly as the analysis becomes more sophisticated. The third step involved a search for additional patterns in the selected text, and the underlying assumptions which shaped the text were identified. Lastly, the functions of particular features of the text were scrutinised. Rhetorical features were sought in the students' statements, e.g. how the underlying assumptions expressed certain ideals or problems.

Study IV: Analysing questionnaire data

In order to investigate the dimensionality of the scale, which was named the Norm-critical awareness scale (NCAS), and to select the most reliable and valid items, confirmatory factor analysis was performed. As measures of model fit, the χ^2 goodness-of-fit test, the root mean square error of approximation (RMSEA), the standardised root mean square residual (SRMR) and the comparative fit index (CFI) were used. The RMSEA is an established tool for evaluating model fit since it takes both the number of observations and the number of free parameters into account (T. Brown, 2006). An acceptable model fit is indicated by values of less than 0.08, and values of less than 0.05 imply a good model fit. SRMR is an absolute fit index and can range from 0 to 1, where 0 is indicative of a perfect model fit and values 0.08 or smaller indicate an acceptable model fit (T. Brown, 2006). CFI compares the χ^2 value of the model to the χ^2 of the null model. Values can range from 0 to 1, but values > or = to 0.95 are indicative of a good model fit (T. Brown, 2006). The reduction of 46 items to 20 was made based on theory, factor loadings, covariances between the factors, face validity and modification indices.

Chapter 6. Research ethics

The aim of this chapter is to describe the ethical awareness, considerations and dilemmas involved in my dissertation work, and to show how the dissertation complies with the Ethical Review Act (Svensk författningssamling, 2003:460).

Ethical approval

The management of the department where the norm-critical project was carried out approved the research project, and ethical approval was obtained from the Regional Ethics Review Board in Gothenburg (nr 289-15). In order to respect and protect participants' autonomy (Beauchamp & Childress, 2009), written and verbal information was given to all potential study participants in studies II-IV, the voluntary nature of their participation was highlighted, and to maintain confidentiality no names or traceable quotes were used in publications. Personal records (data on gender, age, living arrangements, etc.) were obtained during data collection for studies III and IV. However, the records did not contain any information which could be considered sensitive from a legal standpoint (Svensk författningssamling, 2003:460). As the research project progressed, a number of ethical considerations emerged, and these are discussed below.

Ethical considerations and dilemmas

Reflexivity in research requires the researcher to be committed to continuous, critical self-analysis (Finlay & Gough, 2003). As the author of the studies in this dissertation, I am a central figure who actively constructs the collection, selection and interpretation of data.

This is a privileged position, and one which needs to be scrutinised. During the course of this dissertation work, I have been employed (both as a lecturer and PhD candidate) by the department which suggested and provided the case for my dissertation. I did not work at the department before the onset of my doctoral studies, but after my employment I became a colleague of potential participants in study II and a teacher to potential study participants in study III. Researching my own workplace presented me with a number of concerns, although, perhaps naively, I did not think of this as problematic at first. However, the possibility cannot be discounted of (perhaps unintentional) expectations on the researcher to report 'positive' results when the funder also provides the area for research. I have experienced no expectations about my findings whatsoever, but I have been aware of the possibility.

In the following, I highlight some ethical concerns related to each of the four studies. Study I did not involve any human research participants, but may nonetheless have some ethical implications. The syllabi I analysed were written by my colleagues, and the literature was chosen by them. The conclusions of the study are not a criticism of their personal work. It is nevertheless possible that individuals feel 'guilty' about something I mentioned in my text, such as a bad example.

Study II raises a number of ethical concerns. As mentioned above, part of my work time is allocated to lecturing, during which I have been teaching nursing classes at different levels involving norm-critical perspectives in healthcare. Potentially, the division between roles might not have been clear. If I was largely seen as a representative of the ongoing project, the focus-group interviews in study II could have been perceived as a 'homework test', where the participants aimed to give me the 'right' answers. Furthermore, they may have found it difficult to express their honest opinion, because they did not want to hurt me or degrade my area of interest and

expertise. They may have had difficulty being critical because the project was sanctioned by the management of the department. Another aspect of the discussion about double roles is whether the teachers at the department felt that they had to participate in the focus-group discussions. The principle of voluntary participation is stipulated in both national law (Svensk författningssamling, 2003:460) and international declarations (World Medical Association, 2013), and was highlighted in the context of every invitation. However, if the teachers had been invited by a researcher from 'outside', it may have been easier to decline if they had wished to. Being asked by a colleague may have exerted social pressure on them to contribute and to take part because they wanted to appear to be a 'good employee'. The fact that many of the teachers are researchers themselves, and familiar with the importance and difficulty of recruiting research participants, may have made it particularly difficult for them to decline an invitation. Some of the teachers who were invited did decline to participate, which is an indication that the pressure on them to take part was not so great that it could not be overcome.

A focus-group interview poses a risk for invasion of privacy. The researcher can hardly guarantee that the information shared in the group will not be disclosed in another setting. Furthermore, discussions during the interview may be influenced by group pressure involving norms about what it is acceptable to say and what is unacceptable. Smith (1995) suggests that the moderator acknowledge these potential problems in the introductory statements before the interview. This does not solve the problem, but may alleviate concerns in the group. Even though no interview questions involved obvious sensitive personal records or any emotionally turbulent questions, it was not out of the question that participants themselves would bring up their political, religious or philosophical views, for example, during interview sessions. This can be particularly sensitive in a group setting. If this were to occur, I would consider very carefully whether to reproduce this information in a publication. Norm criticism may

evoke personal, and sometimes uncomfortable, opinions. These may be difficult to express if a person feels that there are certain 'correct' answers to norm-critical inquiries. In addition, some participants may belong to groups which are typically not considered 'normal', and they may therefore feel especially targeted. This could make their participation in a group interview particularly sensitive. As a moderator, I had to be attentive to the tone of discussion in the group, and direct the participants back to the questions written in the interview guide if their tone approached anything which could be considered offensive.

Some of the participants may recognise themselves in quotes in published articles, and feel that I have interpreted them wrongly. I have attempted not to use identifiable quotes in manuscripts, but it is still likely that participants will be able to identify their own quotes. Dissatisfaction with how data were treated can be difficult for the participants to handle when the researcher is also a colleague (as in the case of study II) or a potential teacher (as in the case of study III). However, research is not always comfortable. On the contrary, it is sometimes impossible not to present things informants would have preferred to ignore (Bosk, 2003). With this in mind, I have aimed to remain loyal to the study aims and analyses.

Studies III and IV involved a large group of students. Despite the voluntary participation and confidentiality they were guaranteed, they may have felt pressure to participate. It is possible they thought their participation would implicitly affect their grades, and perhaps they felt pressure to provide 'correct' answers, given that they knew norm criticism was part of the department's new profile. Equally, they might have thought they would draw attention to themselves if they left the classroom before responding to the survey. However, not all of the students who were approached chose to participate or answer the open questions, which indicated that the pressure was not inescapable.

Benefits for the teachers who participated in study II included the opportunity to talk and think about special aspects of their teaching, which could contribute to their own learning through reflections which would not otherwise have occurred to them. Their contribution to a research field which is relevant for their work might be less of a direct benefit to them, but could be important when a person decides about whether or not to participate in a study. When it comes to the students in studies III and IV, their main benefit may be similar, and might involve the opportunity to reflect on a subject they would probably not encounter in everyday education. It also gave them an opportunity to contribute their perspectives to research.

As a final point, I return to the fact that the subject of norm criticism can be associated with strong personal opinions, and therefore with a fear that there is a 'correct' set of opinions associated with it. As a researcher, it is important to be aware that a norm-critical project can evoke feelings and can be perceived as offensive or even provocative.

Chapter 7. Study summaries

The aim of this chapter is to present summaries of the four studies and describe their relation to each other. My intention is that they should show aspects of the norm-critical project at University West, ranging from the documents which guide it to the assessment of students who take part in it. Beginning with the basic documents and texts, study I explores the perspectives inherent in curricular documents and literature prior to the project. Study II goes on to explore nursing teachers' initial reflections on the new knowledge they have acquired after the department's first activity of the project: participation in a norm-critical competence-raising course. Study III then takes a student perspective in exploring constructions of norms and normality being present in the classrooms, still in the initial phases of the project. Lastly, in study IV, the focus shifts to possible assessment of students' learning, which can be done at any stage of the project.

Study I

The rationale for study I was the need for knowledge about the dominant perspectives which underpin central documents and course literature in education, and which have not been the subject of any specific norm-critical scrutiny. The aim was to explore whether and how norm-critical perspectives were reflected in the formal documents and literature of nursing education. The dominant outlooks found in the texts were individualised introspection, which appeared to take priority over social awareness, and the contradiction between a somewhat critical rhetoric and biomedically influenced examples of identity categorisation. Despite a degree of promotion of societal awareness, these dominant perspectives could discourage the socialisation of nursing students into advocates of social justice. This lead me to conclude that the politically correct rhetoric which occasionally occurs is little more than rhetoric. Norm-critical

perspectives are mostly absent. In fact, a number of textbooks draw a clear line between the reader and Others, positioning nursing students as the 'normal' who need to learn about Othered cultures and sexualities.

Study II

The rationale for study II involved a need for knowledge about nursing teachers' initial views on norm criticism after they had been introduced to the subject. The aim was to describe the discourses underlying nursing teachers' talk about their own norm-critical competence. Three discourses were identified in their focus group discussions: the discourse of teaching, the discourse of caring and the discourse of personal learning. All of these had some potential to disrupt the conventional nursing education in which the teachers were involved, but they also illustrated the invisible 'normality' among the teachers. This underlying discourse of normality positioned the teachers as exemplifying the 'normal'. The binary constructed between normality and Otherness contradicts a basic tenet of the norm-critical approach, and may hamper the development of norm-critical competence in nursing education.

Study III

The rationale for study III was a need for knowledge about how nursing students construct norms and normality, as they will have authoritative positions with regard to normality in a number of different ways in their future profession. Accordingly, the aim was to explore constructions of norms and normality among nursing students. Four discursive patterns showed variations on how the students constructed norms and normality in their written statements. 'The normal' was laid out as (a) moral guidelines, consisting of easy-to-

digest statements grounded in the profession's moral and ethical values, (b) limiting and frustrating obstacles to personal freedom, which it is important to challenge, (c) an ideal to be obeyed, since conforming to an agreed normality is critical for the sake of society, and (d) a matter of reflection, since it is a person's own responsibility to approach and understand differences in norms, perspectives and opinions between people.

Study IV

The rationale for study IV was a need to assess the preconditions and effects of norm-critical efforts, as this can help to educate groups more effectively at their appropriate level and in areas where they need support. The aim was to develop a valid and functioning scale for measuring norm-critical awareness. From 46 preliminary items, statistical analyses indicated that a summary score of a 20-item scale would reflect general norm-critical awareness among nursing students. The analyses generated support for a scale which would build on the five theoretically derived dimensions of Function, Consequences, Identity, Resistance and Learning. These can be used as subscales in empirical investigations using the NCAS, where Function represents the underlying construct. The scale is intended for – but not limited to – use with nursing students, and could help raise norm-critical awareness in different aspects of the work of human service professionals.

Chapter 8. Discussion

The aim of this chapter is to discuss the findings of the four studies, relating them to the overall aim of the dissertation: to describe and scrutinise norms and normality in a healthcare education context from a norm-critical perspective. The studies are first discussed separately and then jointly. Finally, the chapter discusses overall methodological considerations.

The power of institutional context

In the analysis of documents and literature in study I, the dominant perspectives were individualised introspection, which apparently took priority over social awareness, and the contradiction between critical rhetoric and biomedically influenced examples of identity categorisation. Despite some promotion of societal awareness, the dominant perspectives may discourage the socialisation of nursing students into advocates of social justice.

The choices of perspective and rhetoric in documents and texts are always embedded in larger institutions. It is therefore important to take into consideration institutional rules, norms and expectations in reading study I. The analysis concludes that there is an occasional sense of rhetoric which can be seen as 'political correctness' in the material. However, with norm-critical eyes, this rhetoric seems to be only superficially grounded in values, and is even sometimes contradicted by statements in course literature. On the one hand, institutions promote community, consensus and sustainability, but they also demand discipline, regulation and obedience (Meyer & Rowan, 2006). The findings of study I can be seen from two perspectives: either as an important insight into the professional norms and knowledge of nursing, or as an expression of disciplinary power on how a nurse should be, think and act. Either way, institutions

involve norms, rules and regulations. Their effects lie in that they make people think in certain ways (Douglas, 1986).

Institutions are similar to norms in that they comprise a set of rules which dictate what people expect. These expectations are governed either by formal laws and regulations, or by silent and invisible agreements. Foucault (1975/1995) argued that these norms are internalised by language use, the discourse of the institution. The findings of study I suggest an impression that political correctness is important to discipline in future nurses, in the sense of being particularly aware of the implications of sex and gender in health and care. The limits of 'the normal', on the other hand, are never challenged. This highlights the aspect of disciplinary power in the institution of nursing education. The language use shown in the study may be seen as ways of running the errands of power. If we are assured, through institutional rhetoric, that nothing is wrong with how we live up to values like human rights, social justice, ethical responsibility and so on, then we may not notice the contradictory perspectives which are sometimes shown in the literature. Repeating the institutionalised norm that nursing is intrinsically good helps constitute political correctness. Perhaps this is why some of the text books 'slip through the net', and do not disrupt institutionalised norms and values.

Furthermore, study I suggests that the notions of Otherness and 'tolerance-as-permission' are, to some extent, founded in nursing course literature. Börjesson (2003) points out that categories, values and definitions have a long history. They are produced in self-referring institutionalised contexts, and depend on a number of agreements and procedures. Consequently institutions, like norms, change slowly. Norm-critical perspectives aim to undermine the boundaries that make up the binary between what is seen as 'the normal' and what is not. The results of study I can encourage teachers and students to consider institutional regulations and expectations, and

how they relate to higher goals, such as the ethical responsibilities involved in social justice.

Tolerance as an obstacle to norm-critical development

In study II, nursing teachers discussed the knowledge they had acquired during their recent participation in the university course 'Norm-Aware Caring'. Three discourses were identified in their talk, all of which were constructed from a standpoint of normality, positioning the teachers as examples of 'the normal'. The analysis highlighted the difficulties of reflecting on their own participation in the construction of norms. Nevertheless, the study indicated that there was a positive climate for norm-critical development among the teachers, and that the discourses of teaching, caring and personal learning have the potential to disrupt – or cause trouble for – conventional perspectives in nursing education in a variety of ways.

Previous investigations of norm-critical educational initiatives have shown how a number of norms embedded in the educational context can intersect, e.g. how the notion of a homophobic immigrant minority is presented as a contrast to a homo-tolerant Swedish majority (Reimers, 2010). These kinds of intersection were not directly present in study II, but the act of constructing some groups of people as Others could be sensed among the teachers. By positioning some people as different, and attributing stable and fixed identities to them, the privileged position of the majority norm is strengthened, as shown by Reimers (2010) and others. Education which aims to develop awareness of diversity and minority identities often focuses on the learners (i.e. students), and fails to recognise the identities of the teachers themselves (Allard & Santoro, 2006). This conclusion sheds light on the finding that the teachers appeared not to be aware of their normality, yet they were aware of the differentness of Others.

I return to the concept of tolerance to deepen the analysis of the underlying discourse of normality in study II. 'Invisible normality', as it is called in the article, can be seen from the perspective of tolerance, which has been blamed for leaving the roots of oppression intact. For example, a society which is 'tolerant' in terms of gender, sexuality, religion and ethnicity is still based on heterosexual and ethnocentric norms (Martinsson & Reimers, 2010a). A 'normal' citizen in this type of society is tolerant and heterosexual (Reimers, 2010). Being tolerant, in this sense, involves allowing other perspectives and identities to coexist with the dominant ones without challenging or changing them. When certain ways of being are portrayed as the 'natural' identities, they exert power. This, in turn, positions those who do not comply with the norms as the Other. Norm criticism, however, has the potential to disrupt this reasoning, and this potential was sometimes articulated in the teachers' talk in study II, even if it was not strong enough to form a discourse of its own.

Nevertheless, tolerance is viewed as desirable in the public discourse. In general today, tolerance is uncritically promoted across a wide range of venues and for a wide range of purposes, including objects such as 'cultures, races, ethnicities, sexualities, ideologies, lifestyle and fashion choices, political positions, religions, and even regimes' (W. Brown, 2009, p. 3). As noted by Blommaert and Verschueren (2002), members of a social majority are often – genuinely or strategically – convinced of their own tolerance, because tolerance and openness are highly valued as self-ascribed properties. It is therefore not surprising that traces of tolerance are present in the underlying discourse of normality in study II. Hence, a practical implication of this study is that norm-critical projects need to address the discourse of tolerance more outspokenly, and to show the downsides of approaches that focus on education for and about the Other. A norm-critical goal cannot be to teach students that it is enough to be empathic and tolerant towards the Other, because these qualities do not bring about structural and systemic change. In terms of theory, the

study adds knowledge about the contribution of norm-critical awareness to a context of nursing education.

Norm criticism as identity construction

Study III showed four discursive patterns of norm-breaking and normality among nursing students. They varied in how they positioned themselves in these constructions, echoing both educational influences and experiences from their personal lives. Depending on their outlook, norms were constructed as easily followed moral guidelines, as provocative obstacles for personal freedom, as societal ideals that must be obeyed or as a matter for reflection.

This discussion concerns the second pattern, which constructed norms as obstacles for personal freedom and development. When the students involve themselves as individuals (rather than as healthcare professionals) in their statements about norms, problems and conflicts related to normality become visible. Societal norms appear to interfere with their personal desires, interests and expressions, especially in women. Their statements construct norms as a kind of anti-feminist oppression, against which they rebel. This construction can be seen from the perspective of social identity theory (Hornsey, 2008), which acknowledges norms as crucial information about appropriate ways to think, feel and act in the formation of personal, as well as group identity. It is rare that people relate to each other purely as individuals, with no awareness of social categories. When the students were asked to reflect on norms, one consequence was to enhance their group belonging. The use of patriarchal norms as a reference from which the female students rebel is in line with a strong gender-equality discourse prevalent in Sweden at the moment. Breaking norms of femininity can be a way of developing someone's own identity which, at the same time, confirms the norms of a more feminist context. In this pattern, resistance is constructed as something that is necessary in order to

claim one's identity and personality. The students make statements which favour their own group, as opposed to groups of 'traditional', 'quiet' women. They are constructing a 'new' norm, identifying themselves as modern women, not to be dominated by old-fashioned patriarchal ideas. This pattern raises the question, 'What is made into the norm now?' (Martinsson & Reimers, 2014, p. 32). Norms can be considered good or bad, but in either case, they have effects in terms of new norms and feelings of community or alienation. New norms need to be observed continuously – especially in situations where disciplining into norms is central.

In terms of theory, this discussion suggests that even in questioning old, traditional norms and structures, new 'us and them' distinctions can be created. A practical implication involves the potential use of norm-critical insights in education to train students in self-reflexivity, and to make them aware of the formation of new norms as the old ones are challenged.

Raising awareness through responding to surveys

Study IV, carried out in two phases, generated a 20-item scale, through which a summary score can be used to capture respondents' overall norm-critical awareness. The items were distributed over five theoretically derived dimensions, and tested in a sample of nursing students at different stages in their education. Further studies are needed to validate the scale fully, but the scale construction process indicates that norm-critical awareness can be operationalised with the theoretically derived NCAS. The scale can help improve the quality of evaluations of norm-critical educational efforts, legitimise them, and suggest which dimensions of norm-critical awareness are particularly high or low in a group or context involving issues of prejudice, discrimination and marginalisation.

Hagey and MacKay discuss the development of an assessment tool in their description of an anti-racist project in Canadian nursing education (2000). The tool was expected to provide research leverage to generate accountability and make their anti-racist project visible, and it was intended to be used to assess progress towards the goal of incorporating anti-racism into the curriculum. The NCAS is intended to be used in a similar awareness-raising manner. However, previous studies which aim to develop nursing-related scales, tools or models have been vague in defining the awareness concept. From a social justice perspective, awareness involves the process of exploring how Others are designated vulnerable or privileged, and how systems of oppression foster this type of categorisation (Boutain, 2005). Rew et al. (2003) conceptualise awareness as an affective dimension, thereby separating it from attitudes, knowledge or actual skills. Holmström et al. (2017) suggest that 'awareness of inequity is likely to affect the nurse-patient encounter' (p. 135), while Milne et al. (2016) define awareness 'as the beginning of a process', and point out that 'awareness of difference' is important for cultural safety (p. 21). In the context of cultural competency, awareness is considered to involve self-examination and in-depth exploration of one's own background, as well as recognition of one's biases, prejudices and assumptions about individuals who are seen as 'different' (Campinha-Bacote, 2002).

Following this reasoning, it is open to question how meaningful it might be to capture a concept such as awareness on a measuring scale. Awareness is, of course, no guarantee that a problem will be avoided (see, for example, Fairclough, 2015). Merely raising individuals' conscious awareness of a particular matter does not ensure the acquisition of practical competence. Blommaert and Verschueren (2002) even claim that what they call 'Foucauldian awareness' (p. 21) in terms of social life is no guarantee that people will avoid the kind of rhetoric which contradicts widely accepted critical beliefs and attitudes. However, Boutain's (2005) model of social justice

transformation underlines that awareness is the start, not the goal, of a transformation process. If a measuring scale can make respondents aware of their feelings and emotions, this is an important starting point for a process of change (Randall, 1994). Surveys are also a form of interaction which create meaning. In the light of this, responding to the NCAS may raise students' awareness and simultaneously indicate a starting position for further development of norm-critical awareness that can lead to stages of change.

In terms of theory, study IV adds another perspective to the field of assessment tools for use in nursing education by presenting a scale which aims to capture awareness of overall norm-critical principles. In a practical sense, it can be used in (but is not limited to) nursing student populations to raise awareness, assess the level of norm-critical awareness and help design educational initiatives.

Joint discussion of the four studies

Institutionalising norm criticism

In writing a dissertation based on the assumption that norm-critical perspectives can make significant contributions to healthcare professionals, it is necessary to reflect on whether the concept of norm criticism risks being established as a new, static norm in anti-oppressive and anti-discriminatory work – a pre-packaged solution to challenging issues. Critical traditions themselves must also be exposed to criticism (cf. Qvarsebo, 2019). Critical theory, for instance, is an academic field engaged in theories which attempt to confront issues of power, privilege and hegemony. It has been criticised for reproducing power relations and constructing its own regime of truth (Rogers et al., 2005). It has also been accused of being 'the words of white men engaged in conversations with themselves' (Yancy, 1998, p. 3).

Norm criticism has been accused of falling into the same trap, creating new exclusions and hierarchies, only on different grounds. Langmann and Månsson (2016) argue that all advocates of norm criticism are facing a dilemma: the distinction which is inevitably made between 'us who are norm-critical' and the others. In this way, norm-critical pedagogy is both creating and excluding 'strangers' who do not fit into the norm-critical rationality of challenged and disrupted norms, binaries and boundaries. These strangers are in danger of being seen as different and looked down upon, not fitting into the norm-critical norm. Even though self-reflexivity is recurrently highlighted as central to norm-critical understanding, critics claim that the norm-critical discourse in itself is not reflexive in terms of its own values and preferences (Qvarsebo, 2019).

On a similar note, in their study of acts of resistance among young people, Johansson and Lalander (2012) underline that the purpose of resisting can never be to replace one regime with another. This means that even if norm criticism is viewed as a strategy of resistance, it should not be welcomed uncritically as a new regime. Hopefully, the reflexivity which is built into the norm-critical framework can prevent it from stagnating into a static and authoritative approach, as long as the reflexive perspective is broad enough to include the consequences of new hierarchies. There will never be a set of norms that 'everyone' agrees on. Instead, norm-struggles must be permitted and considered legitimate (Martinsson & Reimers, 2014). However, this does not mean that 'anything goes', because certain norms are, in fact, preferable from a norm-critical perspective. Theodorsson (2018) suggests that the apparent contradiction that norm criticism can turn into a norm in itself is resolved if norm criticism is seen as normative: not all norms are equally desirable, and not all norms should be criticised. The 'regime' of norm criticism is founded in values such as universal human rights and anti-discrimination.

Developing an instrument in study IV can be seen as a contribution to institutionalising norm criticism as a tool in educational contexts. Qvarsebo (2019) criticises norm criticism for being a new form of moral governing, except that it uses more desirable norms than in 'the perceived unenlightened past' (p. 11). Surveys and instruments, where the desirable outcome is obvious, can be seen as tools that govern thinking and acting in education contexts. I agree that in work focused on anti-discrimination and systems of values, norm criticism operationalised into a scale could develop into a 'quick fix' for profound and complex problematics, resulting in shallow, politically correct rhetoric.

Foucault pointed out that a strong focus on identifying certain kinds of oppression in society comes with risks. The idea of an authentic, oppressed subject is not only incorrect, it is harmful (Foucault, in Hörnqvist, 2012). If we become too concerned with the emancipation of some oppressed essence within ourselves, we also risk becoming overly concerned with these essences – whether it be sexuality, ethnicity, femininity or something else. Constantly highlighting the importance of emancipation from the oppression of categories such as womanhood means that, at the same time, we reproduce this oppressive category. Butler (1993) reminds us that norms are established through repetition in our everyday lives. In our efforts to criticise the expectations and oppressions that come with gender, age or class, we simultaneously endorse the categorisations alongside making them stronger. The Other, then, will have trouble breaking free from these categorisations. I have encountered this same problem in my writing about norms and hierarchies. The positions of norm-bearers and norm-breakers are shifting and contextual, but describing the normative positions of certain people and groups might also confirm them.

Lastly, it can be noted that 'criticism' in the concept of norm criticism is not a general criticism of social norms. Norm criticism should not be confused with the idea of a norm-less social world. It does not aspire to a general anti-normativity (cf. Henriksson, 2017). Normativity, in the sense of having values that one believes in, is much too powerful a concept to be disrupted by norm criticism. Norm criticism is not about anti-normativity, but can be helpful in destabilising what is held as 'the truth', in order to reach normative goals such as equity in healthcare and social justice in health.

The awareness phase of change

Returning to Boutain's (2005) model of social justice for a joint understanding of this dissertation, it becomes clear that the studies address the awareness phase of the model. This was to be expected, because the project which was studied is still in its early phases. Boutain points out that awareness of social justice is temporal and dependent on the frame of reference; it is a process where one continues to move, sensing different aspects of injustice depending on one's outlook. The second step of the model, following awareness, is amelioration, which involves addressing the immediate results or antecedents of unjust conditions. Amelioration, however, does not change any of the structural conditions of injustice. It is the next step, transformation, that aims to change or develop structures and conditions which foster unjust situations. Awareness can thus be seen as a point of departure for deeper understanding and action. Simply talking about issues related to norms can increase awareness of them, just as merely elevating a conversation about caregiving is powerful and can lead to endless action (Cordano, Johnson & Kenney, 2015).

Some previous studies have described work which aims to change norms in a nursing faculty context. Directing norm-critical efforts at a specific university does not mean this institution is particularly 'bad' (cf. Schreoder and DiAngelo, 2010), but since workplaces form part

of wider society, they too are marked by unacknowledged norms and beliefs. This dissertation shows that a norm-critical project can at least create a state of awareness.

Relevance to other professions

The case for this dissertation is taken from a nursing context. However, many of the problems relating to norms, normality and power are more general than this. In all human service work, actions are primarily normative and represent moral choices, although professionals are often unaware such choices have been made (Hasenfeld, 1992). Hasenfeld also points out that all human service organisations embody values of caring, commitment to human welfare, trust and responsiveness to human needs. Because of these shared values across organisations, it may be possible to apply norm-critical reasoning to human services other than nursing. For example, anti-oppressive practice is established within social work (see, for example, Dominelli, 2002), and in Sweden the approach of social workers to issues of norms, hierarchies and identity categorisation has been addressed by researchers such as Eliassi (2015, 2017), Fernqvist (2018) and Mattsson (2014). This suggests that norm criticism has relevance in broader contexts which involve power, relationships and hierarchies.

Overall methodological considerations

Considerations involving reflexivity

Many scholarly texts underline the importance of the researcher's reflexivity, typically as assurance of the integrity and trustworthiness of qualitative research (Finlay, 2002). Throughout this dissertation work, however, I have considered reflexivity to be more than a means

of legitimising methodological choices. It is a practice in which a researcher should engage, and which leads to a self-aware meta-analysis of the research process. This should also be conveyed to the reader. Finlay (2002) argues that being reflexive means continually analysing the dialectic relationship between subject (me, the researcher) and object (the phenomenon which is explored). Throughout my four years of research education, the distance between myself and the object of my research has become more and more apparent, where it was not particularly clear at the beginning. My previous occupation involved development and change in organisations, so I carried some of this mindset into the researcher role and viewed myself as more of a 'doer' or an 'activist' than a knowledge producer.

In research which claims to have a critical stance, reflexivity is perhaps of particular importance. Without reflection on the fact that a critical position is also very normative, the chances are that the researcher will take an elitist position, subtly claiming to know the 'correct' way of thinking, acting and seeing things. A critical position suggests that the researcher has seen through something others have not. My own view of myself within a critical framework has changed throughout my dissertation work, from seeing my role as an elevated ideal to seeing the problems that come with it. Overall, my focus has shifted slightly, from seeing my research as a way of changing things, to seeing it as something which produces knowledge in itself. To some extent, taking a 'critical' position leads to the same dilemmas norm criticism has been accused of being unable to resolve. It creates a divide between those who feel they are in the superior position of being 'right', and those who are not yet enlightened. The reflexive process has increasingly made me problematise the critical stance and its potential hierarchy in terms of other positions.

During the work, I have struggled with my own professional belonging. Not being a nurse or any kind of healthcare professional

myself, I have sometimes felt that I did not have a legitimate reason to apply a critical perspective to a field which is not even my own. On the other hand, this meant that I was in no way socialised into the field, which gave me the opportunity to make observations and analyses from a certain distance. This probably enabled me to act more freely than someone with a strong foundation in nursing science and practice might have done.

Considerations involving the quality of qualitative research

There is still no consensus on what constitutes quality in qualitative research paradigms, even though attempts to establish positivist-inspired terminology have generated some support (Rolfe, 2006). Quality-type terminology such as credibility, transferability, dependability and confirmability (Guba, 1981) is based on assumptions of objectivity and essentialism, which are not particularly compatible with a constructionist approach. Instead, establishing the trustworthiness of a study can be seen more as the job of the reader than the responsibility of the researcher. According to Rolfe (2006), we should not expect either expert researchers or respondents to arrive at the same themes and categories as the researcher, which is why any attempt to increase reliability involves a 'forced or artificial consensus' (p. 305). Because of the possibility that a study participant will not recognise or agree with a researcher's interpretation of their words or actions (Grant & Giddings, 2002), quality-establishing techniques such as member-checks do not seem appropriate from a constructionist point of view. Instead, as Potter (1996) argues, perhaps the most powerful way to approach validity in discourse studies is to present passages, or preferably full transcripts, of the text which has been analysed. In this way, readers are allowed to make their own evaluation, and put forward alternative interpretations.

On a similar note, the issue of generalisation in qualitative research is both complicated and controversial (Polit & Beck, 2010).

Generalisation involves the potential use of a piece of research, but there is no agreement among qualitative researchers about either the importance or the attainability of generalisation (Larsson, 2009). Of course, generalisation is important in being able to apply study findings to people, situations and times other than those in a particular study, but the applicability of qualitative research findings can be viewed from more perspectives than conventional generalisability. Larsson questions whether the term 'generalisability' has a single meaning, and claims that it needs to be applied differently in different kinds of research. Generalisation based on a positivist view, using strict sampling from a defined population, is limited to a certain kind of research. This would not be very useful in qualitative discourse-inspired investigations.

The general approach taken to the issue of generalisability in studies I-III of this dissertation is what Larsson calls 'recognition of patterns' (2009). Patterns in research are the basis for generalisations and can be descriptions, concepts or theoretical constructions. The study context offers a hint of where to look for similar patterns, but context alone cannot predict the cases in which the interpretation is useful. Recognising a pattern in any research can be referred to as 'realisation'. Someone who is familiar with a piece of research realises that the qualitative interpretation in the study 'fits' other situations with which they are familiar.

I agree with Larsson that a piece of qualitative research offers a way of interpreting cases other than the original, which is the expectation of the findings in studies I-III. Regarding the generalisability of the results in study IV, purposive sampling lessens the possibility of generalising the NCAS structure to all nursing student populations in Sweden. However, it is still possible to use the scale as a starting point for further studies in different populations.

Considerations involving discourse

Using discourse-inspired methodology is still relatively rare within nursing science, and discourse analytical research has been met with some criticism (Buus, 2005). Even its proponents admit that post-structural approaches should not be viewed as privileged or mandatory (Cheek, 2000). Instead, it is important to allow for a variety of methodological and theoretical frameworks, and to use ones which are appropriate to the circumstances and purpose of research. Buus (2005) claims that even when discourse analysis is used, its suggested differences from mainstream qualitative methods are unclear, and that there is confusion over definitions, as well as inconsistency in links between theory, method, application and conclusions. Readers are often not given the insights required for understanding how data are analysed which, in turn, makes them question the relevance of the conclusions.

It is important to consider the question of what a discursive approach can contribute, particularly in studies II and III. For all discourse studies, the most useful starting point is 'the suspension of the belief in the taken for granted' (Gill, 2000, p. 178). I opted to work with discourse analytical methodology in an attempt to move away from the essentialist assumption that forms the basis for a number of conventional qualitative methods, and to highlight language use as constructing and constituting, as well as being constituted by, social practice. For instance, the role of grammar, metaphors and word choices in discourse analyses differs from how language is viewed in conventional qualitative approaches.

The findings of study I can also be viewed from a discourse perspective. The implication of viewing text as socially constituting is that the analysed documents and texts are not only texts attached to educational practices, they constitute the social practice of education, which means that they also carry power. According to Maw (1993), all curricular texts develop from, and contribute to, a particular set of

discourses. There is a naivety in interpreting policy documents as transparent expressions of intent, as they could mask the fact that actors 'employ discourses with varying degrees of naivety, reflectiveness and purpose, and change them in the process' (Maw, 1993:57). The context in which a text is produced has implications for how it exerts power. Thus, the power of discourses can be attributed partly to institutional power. From this perspective, study I can be seen as a study of discourse.

In study II, I aimed to avoid common inconsistencies in the use of discourse methodology highlighted by Buus (2005), as the CDA methodology is compatible with assumptions that inform the theoretical framework of norm criticism. They both draw on theory which emanates from both radical and post-structuralist intellectual traditions. Study III does not specifically draw on CDA, but on a framework for discourse analysis suggested by Gill (2000). The focus of the study involved constructions as they could be seen in written language, and the framework, which was inspired by critical linguistics, rhetoric and post-structuralism, fitted this aim well.

Critique which is often directed at the constructionist stance is connected with moral relativism. If values are seen as social constructions, there is no basis for moral behaviour, and if anything goes, it leaves no ground for criticising oppressive ideas (see, for example, Gergen, 2015; Hacking, 1999). However, from an emancipatory perspective, some states are better than others. To take an example, feminism is not an *alternative* to racism, sexism or classism, but *preferable* (Allen, 2001, italics in original). Gergen (2015) points out that nobody involved in constructionist ideas ever said that 'all values are equal' (p. 226). Quite the contrary, constructionism opens up a space for feminists, minorities and all of us to challenge the 'truth' and the 'facts' of the dominant order, claims which are very similar to those of norm criticism.

Considerations involving measurement

The use of rating scales is a conventional method of determining the outcomes of initiatives in educational contexts, even though no assessment method can extract from people what they have learned or changed in their mindset. Norm criticism claims to be different from conventional pedagogic approaches, and assessment of whether outcomes of norm-critical projects are 'successful' or not may therefore need to use unconventional methods. However, we live in an 'audit society', where quantifiable results are necessary for strategic decisions (Power, 1999). In this light, the scale that was developed in study IV can be seen as an attempt to mainstream and legitimise the project, making norm-critical awareness 'real' in a quantifiable way. This raises concerns about whether the kind of institutionalisation that comes with making something measurable might take away the transformative character of norm criticism. By turning it into an activity which can easily be ticked off on a checklist, the quantifiable results can become more important than the actual norm-critical work.

Van Herk et al. (2011) have claimed that there are few tools available to help nurses recognise unearned privilege and normative positions. There is also a need for models which nurses can use to engage in the kind of reflective practice that would encourage them to position themselves within a larger societal context (Gustafson, 2007). A norm-critical approach can help to fill these gaps, and the instrument developed in study IV can be used as one of many pedagogic tools in raising norm-critical awareness.

Chapter 9. Conclusions and implications

Finally, this section will set out the conclusions and implications I have drawn from my four studies.

Conclusions

From study I, it can be concluded that the politically correct rhetoric which occasionally occurs in documents and texts appears to be little more than rhetoric. Several textbooks draw a clear line between 'us' and 'them', positioning the reader – the nursing student – as 'the normal' person who needs to learn about 'other' cultures and sexualities.

Study II concludes that norm criticism is a potentially useful perspective in a context of healthcare education, partly because of the focus of nursing care on encountering each individual on their own terms. Simultaneously, there are challenges in using self-reflexive reasoning in the initial knowledge development process with nursing teachers.

Study III concludes that, from a student perspective, there is a need to develop power-conscious and self-reflexive thinking within the frameworks of nursing education, and that a potential benefit of the contribution of norm criticism would be its focus on scrutiny of an individual's own position and the privilege that comes with it.

From study IV, it can be concluded that the theoretically constructed and validated NCAS can be used as a summary measure of norm-critical awareness, and that norm-critical awareness can be captured by five theoretically derived dimensions on a 20-item scale.

Taken together, the dissertation concludes that the concept of tolerance needs to be problematised more in the context of healthcare education, and that awareness is a first and necessary, but not sufficient, phase of change.

Practical and theoretical implications

This dissertation brings forward norm-critical perspectives in a context of nursing education, adding to the existing research traditions of critical, emancipatory and anti-oppressive perspectives on healthcare professions. Some suggestions are outlined from the four studies which can facilitate understanding, planning and implementation of further norm-critical initiatives.

A practical implication of study I is to review formal documents and literature which govern education programmes for future healthcare professionals. In terms of theory, the study shows how certain problems associated with the perspective of tolerance become visible in the texts through the lens of norm criticism. Future research should study the changes norm-critical analyses can bring about in such texts, and how the changes might affect education.

Study II also points to the importance of challenging the perspective of tolerance in designing and carrying out norm-critical projects. In terms of theory, the study adds knowledge regarding the context of norm-critical learning. Future research should continue to investigate teachers' competence as they grow more accustomed to norm-critical perspectives and begin to implement them in their own teaching.

Implications of study III include using norm-critical insights in education in order to encourage self-reflexivity in students. In terms of theory, the study adds knowledge on nursing students' contributions to establishing norms and normality in their professional life, as well as

in personal contexts. Future research should explore students' constructions of normality in more depth in practical situations, such as through observations in clinical training.

In a practical sense, study IV can contribute to assessing and evaluating norm-critical projects. The suggested scale can raise awareness, help direct educational focus, assess the consequences of interventions and improve legitimacy. From a theoretical perspective, the study adds knowledge about theoretical dimensions of norm-critical awareness as a statistical construct. Future research should continue to validate the NCAS against established scales and concepts.

Taken together, this dissertation exposes a number of constructions of the normative, taken-for-granted aspects within healthcare education, and suggests that the use of an assessment scale could be one way of increasing awareness of norms and normality. The studies fill a knowledge gap in terms of the contribution of norm criticism to settings where future healthcare professionals are being educated, which have previously barely been explored. In a practical sense, the dissertation can act as inspiration and support for future norm-critical initiatives in similar contexts. Future research should explore later phases of norm-critical change in depth.

A norm-critical perspective can offer new insights into the approach to normality taken in healthcare contexts. Normality as a concept exists in nursing's knowledge production, although the latter is considered to be essentially different from biomedicine. 'The normal' is constructed by central agents of education: teachers, students and texts. The use of norm criticism as an educational and intellectual tool can therefore increase students' awareness of norm-related mechanisms at play when they encounter, meet and treat patients in their role as nurses. This dissertation appears to indicate that norm criticism can shed some

light on a number of blind spots in the underlying assumptions of healthcare education.

Summary in Swedish/Sammanfattning på svenska

Den här avhandlingen handlar om en normkritisk satsning i sjuksköterskeprogrammet på Högskolan Väst. En kort tid efter att den inletts, påbörjade jag mitt avhandlingsarbete. Jag har studerat satsningen utifrån några olika perspektiv: riktlinjer och litteratur, lärare, studenter och ett möjligt mätbarhetsperspektiv. Avhandlingen består av fyra delstudier samt en kappa, den längre text som ramar in delstudierna och deras huvudsakliga fynd.

Bakgrund

Både internationellt och i Sverige har vårdsystem kritiserats för att inte leva upp till de ideal som finns om jämlik vård till alla. Det har framförts olika skäl till att ojämlikhet förekommer i vården – dels strukturella aspekter relaterade till organisation och ekonomi, dels sådana som lyfter fram interpersonella aspekter, personliga värderingar, fördomar, attityder och normer. Med utgångspunkt i det senare är bemötandet viktigt för att förstå varför ojämlikhet uppstår. Det är förstås få professionella i vården som medvetet låter fördomar eller personliga uppfattningar om patienter styra vården, men sociala normer kan påverka oss även omedvetet, eftersom de är djupt inristade i oss. Om det i samhället finns en outtalad norm om att vissa typer av människor är mer förtjänta av vård än andra, är det fullt möjligt att denna norm följer med de professionella in i deras praktik.

Satsningen på Högskolan Väst tar sin utgångspunkt i att professionellas ofta omedvetna normer kan påverka hur de möter och vårdar olika patienter och patientgrupper. För att utbilda sjuksköterskor som är medvetna om sina egna – och samhällets –

normer, och hur de skulle kunna påverka bemötandet, behöver dessa frågor ges utrymme och fördjupas i utbildningen.

När jag har studerat satsningen, har jag använt mig av normkritisk teori som övergripande teoretiskt ramverk. Den normkritiska pedagogiken utvecklades i Sverige under 00-talet och har fått stort genomslag, men också givit upphov till mycket debatt och kritik. En grundläggande tanke i utvecklingen av normkritiken var att erbjuda ett alternativ till den så kallade toleranspedagogiken, som var populär i antidiskriminerings- och värdegrundsarbete runt millennieskiftet. Den välmenande toleranspedagogiken gick ut på att skapa tolerans för det ’annorlunda’ i arbete i skolan. I denna ambition glömdes maktperspektivet bort: den som har möjlighet att tolerera någon annan intar samtidigt en överlägsen maktposition över denna. Denna insikt är viktig för att kunna arbeta med förändring av maktpositioner och hierarkier och för att kunna rikta blicken mot normen, istället för mot den som avviker från normen.

Normkritiken har använts för att beforska olika perspektiv, särskilt vad gäller skapandet av kön och genus i skola och förskola, men den har också implementerats i högre utbildning och på bl.a. produktdesign. Min syn på normkritiken är som ett intellektuellt förhållningssätt som inte är begränsat till undervisningssituationer, utan ett sätt att tänka på relationer, hierarkier och perspektiv i relation till ett visst normativt värde, exempelvis jämlikhet i vård. Genom kritisk forskning i det hälso- och vårdvetenskapliga fältet har det sedan decennier funnits ett intresse för olika typer av maktrelationer, men ett specifikt normkritiskt perspektiv har inte använts i tidigare studier inom fältet.

Syften

Syftet med avhandlingen är att beskriva och granska normer och normalitet i en vårdutbildningskontext ur ett normkritiskt perspektiv. Ett ytterligare syfte är att utforska hur ett normkritiskt perspektiv kan bidra med ny kunskap till redan existerande kritiska kunskapsfält.

De specifika syften som har väglett de enskilda studierna är:

- Att beskriva underliggande normer i för sjuksköterskeutbildningen centrala dokument och texter
- Att utforska hur lärare beskriver sin egen introduktion till det normkritiska fältet
- Att utforska de perspektiv på normer och normbrott som studenter bär med sig under utbildningen
- Att utveckla ett instrument som operationaliserar och mäter normkritisk medvetenhet

Metoder

Det normkritiska projektet på Högskolan Väst har utgjort ett ’fall’ för mina studier av normkritik i en vårdutbildningskontext. De är kvalitativt orienterade med undantag för studie IV, som har både kvalitativa och kvantitativa inslag.

I studie I studerade jag genom tematisk analys underliggande normer och normaliteter i de centrala riktlinjer och kursplaner som styrde utbildningen vid tidpunkten för det normkritiska projektets start, samt den kurslitteratur som fanns specificerad i dessa kursplaner. Kursplanerna läste jag i sin helhet, medan läsningen av litteraturtitlarna styrdes av vissa nyckelord kopplade till normkritik och jämlik vård.

I studie II intervjuade jag lärare på sjuksköterskeprogrammet i fokusgrupper strax efter att de genomgått en introduktionskurs till det normkritiska perspektivet. Jag analyserade deras diskussioner om sitt eget lärande med utgångspunkt i kritisk diskursanalys, en metod som fokuserar både på ordval och den kontext som texter skapas i, samt relationen däremellan.

I studie III analyserade jag med ett diskursivt ramverk 154 studenters skriftliga utsagor om normer och normbrott. En diskursiv syn på text innebär att se den som skapare av kunskap, snarare än som en spegling av kunskap som redan finns i världen. Dessutom har text alltid en funktion, t.ex. att övertyga läsaren om vad som är rätt, att erbjuda lösningar på problem, eller att visa på en orimlighet.

I studie IV utvecklade jag ett instrument för mätning av normkritisk medvetenhet. Detta var en process i flera steg. Inledningsvis formulerades enkätfrågor med utgångspunkt i normkritisk litteratur, vilka bedömdes av en expertpanel. Genom pilotstudier bland studenter bedömdes vissa frågor som icke-relevanta och sorterades bort, medan andra formulerades om. Djupare diskussion kring de kvarvarande frågorna fördes i en mindre grupp av studenter. Slutligen samlades data in från 209 studenter som besvarade den reviderade enkäten. Genom statistiska analyser av deras svar kunde antalet frågor reduceras ytterligare.

Resultat

Studie I visade hur ’politiskt korrekta’ formuleringar om värderingar kopplade till vissa identiteter och kategoriseringar synliggjordes i de kursplaner som studerades. I litteraturen dominerade förlegade uppfattningar om normalitet och ’annorlundahet’, och det var tydligt att den tänkta läsaren var en vit, kristen, svensktalande sjuksköterskestudent.

I studie II urskildes tre olika diskurser i lärarnas tal om deras introduktion till det normkritiska fältet. De uttryckte sin syn på normkritik genom en vårdande diskurs, en undervisande diskurs och en diskurs som utgick från deras egen personliga utveckling. Det framstod som om det fanns potential för utvecklingen av det normkritiska perspektivet, samtidigt som det var svårt för lärarna att se på sig själva som bärare av normalitet.

Studenternas utsagor i studie III visade hur normer och normbrott kunde konstrueras på mer eller mindre reflekterande och självreflexiva vis och hur de kopplades till antingen yrkesetik eller personliga erfarenheter. I en grupp framstod brott mot traditionell kvinnlighet i sig självt som en norm. En annan grupp relaterade sin syn på normer till vad de lärt sig att en sjuksköterska ’ska’ tycka. En mindre grupp uttryckte oro för normbrott ur ett samhällsperspektiv och menade att det fanns en hänsynslöshet i att strunta i att följa överenskomna normer. Slutligen fanns också de studenter som såg olika normativa uppfattningar som något som kunde överkommas med hjälp av individuell reflektion och ambition att skapa förståelse för olika människors perspektiv.

Studie IV visade utvecklingen av en mätskala med syfte att uppskatta normkritisk medvetenhet. Den slutliga mätskalan kallades ’The Norm-critical awareness scale’ och bestod av fem teoretiska dimensioner och 20 enkätfrågor. Dimensionerna utgick från centrala områden inom den normkritiska litteraturen och var fokuserade runt funktionen av normer; normers relation till identitet; lärande och normer; normers konsekvenser samt motstånd och normer. Denna skala föreslogs användas för att t.ex. uppskatta förändringar i normkritisk medvetenhet i grupper, men också som en utgångspunkt för diskussioner kring normkritiska ämnen. Att använda en mätskala för att visa på kvantitativa resultat kan dessutom i sig öka legitimiteten för normkritiska projekt.

Slutsatser och implikationer

Min avhandling som helhet ökar kunskapen om normkritiska perspektiv i en vårdutbildningskontext. Studierna visar på olika konstruktioner av och perspektiv på det för givet tagna i en sjuksköterskeutbildning och att det positivt klingande begreppet tolerans behöver problematiseras mer i relation till normer, privilegier och makt. Att använda normkritisk teoribildning som både ett intellektuellt och ett pedagogiskt verktyg kan öka medvetenheten om normrelaterade aspekter i möten med människor, särskilt i vårdmöten, och vad konsekvenserna av dessa kan bli. Medvetenhet är ett första steg i arbete som syftar till förändring av strukturer och förhållningssätt, men inte ett tillräckligt. Därför är det viktigt att se medvetandegörandefasen som just en första fas som behöver följas av konkret förändring.

Vad gäller den praktiska användningen av avhandlingen så kan fynden underlätta förståelse, planering och implementering av framtida normkritiska projekt i utbildningskontexter. Från ett teoretiskt perspektiv bidrar avhandlingen till att fylla en kunskapslucka vad gäller normkritiska perspektiv på vård och vårdutbildning. I förlängningen kan detta bidra till att studenter och sjuksköterskor blir lite mer medvetna om sina egna ’blinda fläckar’.

Attachments

Interview guide, study II

Vilka erfarenheter har ni av normmedvetenhet (vid sidan av kursen)? Personliga/professionella?

Kan ni ge ex på ny kunskap hos er själva? Hur resonerade ni om de här frågorna innan kursen?

Hur ser ni på er egen kunskapsutveckling?

Vilka verktyg har ni fått för att problematisera dolda normer i undervisning och vårdmiljö?

Hur ser ni att er nya kunskap kan samordnas med er tidigare kompetens?

Vilka möjligheter ser ni med att implementera normmedvetenhet i ssk-programmet?

Vad ser ni som mest angeläget att förändra i er undervisning?

Vilka hinder kan det finnas för att implementera normmedvetenhet?

Finns det situationer när normmedvetenhet inte är möjlig?

Hur ser ni på normmedvetenhet som ett förhållningssätt för att bidra till en mer jämlik vård? Kan ni ge exempel?

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